MEDICARE REIMBURSEMENT OF HMO's

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON FINANCE

UNITED STATES SENATE

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FIRST SESSION

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MEDICARE REIMBURSEMENT OF HMO's

JULY 30, 1981

U.S. SENATE,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON FINANCE,
Washington, D.C.

The subcommittee met, pursuant to notice, at 2 p.m., in room 2221, Dirksen Senate Office Building, Hon. David Durenberger (chairman) presiding.

Present: Senators Durenberger and Bradley.

[The committee press release and Senator Heinz's opening statement follow:]

HEARING ON MEDICARE REIMBURSEMENT OF HEALTH MAINTENANCE ORGANIZATIONS

The Honorable Dave Durenberger, Chairman of the Subcommittee on Health of the Senate Committee on Finance, announced today that the Subcommittee will hold hearings on Thursday, July 30, 1981, to review the current HCFA demonstrations providing for medicare reimbursement for HMO's and to provide an opportunity to hear comments on additional suggested methods of reimbursement for HMO's and other prepaid health plans. The hearing will also focus on State experiments with prepayment contracts for their medicaid recipients.

The hearings will begin at 2 p.m. in Room 2221 of the Dirksen Senate Office Building.

Senator Durenberger noted that "the Federal and State HMO demonstrations provide us an opportunity to examine in detail the appropriateness of these methods of reimbursement, with a view towards long-term policy changes."

It is anticipated that witnesses will include representatives of Federal and State agencies, private organizations, as well as representatives of the organizations involved in the demonstrations.

Requests to testify.—Witnesses who desire to testify at the hearing must submit a written request to Robert E. Lighthizer, Chief Counsel, Committee on Finance, Room 2227 Dirksen Senate Office Building, Washington, D.C. 20510, to be received no later than the close of business Monday, July 20, 1981. Witnesses will be notified as soon as practicable thereafter whether it has been possible to schedule them to present oral testimony. If for some reason a witness is unable to appear at the time scheduled, he may file a written statement for the record in lieu of the personal appearance. In such a case, a witness should notify the Committee of his inability to appear as soon as possible.

Consolidated testimony.—Senator Durenberger urges all witnesses who have a common position or who have the same general interest to consolidate their testimony and designate a single spokesman to present their common viewpoint orally to the Subcommittee. This procedure will enable the Subcommittee to receive a wider expression of views than it might otherwise obtain. Senator Durenberger urges that all witnesses exert a maximum effort to consolidate and coordinate their statements.

Legislative Reorganization Act.—Senator Durenberger stated that the Legislative Reorganization Act of 1946, as amended, requires all witnesses appearing before the Committees of Congress "to file in advance written statements of their proposed testimony, and to limit their oral presentations to brief summaries of their argument."

Witnesses scheduled to testify should comply with the following rules:

(1) All witnesses must submit written statements of their testimony.

(2) All witnesses must include with their written statement a summary of the principal points included in the statement.

(3) The written statement must be typed on letter-size paper (not legal size) and at least 100 copies must be delivered not later than noon on Wednesday, July 29, 1981.

(4) Witnesses should not read their written statements to the Subcommittee, but ought instead to confine their oral presentations to a summary of the points included in the statement.

(5) Not more than five minutes will be allowed for the oral summary.

Written statements.—Witnesses who are not scheduled to make an oral presentation, and others who desire to present their views to the Subcommittee, are urged to prepare a written statement for submission and inclusion in the printed record of the hearing. These written statements should be typewritten, not more than 25 double-spaced pages in length, and mailed with five (5) copies to Robert E. Lighthizer, Chief Counsel, Committee on Finance, Room 2227, Dirksen Senate Office Building, Washington, D.C. 20510, not later than Friday, August 14, 1981. On the first page of your written statement please indicate the date and subject of the hearing.

Prepared Statement by Senator John Heinz

I want to commend Chairman Durenberger for scheduling this hearing in order to examine the very important issue of reforming medicare and medicaid reimbursement to HMO's and other prepaid health benefit plans. As the distinguished chairman knows, the subject of medicare reimbursement to HMOS's and other health plans is an area in which I have had a keen interest for some time. I recently introduced legislation, the Competitive Health and Medical Plan Act (or CHAMP), along with Senators Moynihan, Cohen, Melcher, and Chiles, that would reform medicare to prospectively reimburse HMO's and other prepaid plans, which are referred to as competitive medical plans, or CMP's.

Mr. Chairman, as chairman of the Aging Committee, I am troubled by two growing problems—problems that are of no less concern to my colleagues on this committee—that is, skyrocketing medicare costs, and shrinking medicare benefits.

At the same time, the plight of the social security trust funds is an issue which has, and will continue to demand, our attention, because the social security trustees have recently reported that the medicare trust fund may go broke as early as 1989.

At the root of soaring medicare costs is a rate of growth in hospital costs that continued to outstrip the growth rate of wages and prices.

On the benefit side, medicare covers only about 38 percent of the elderly's total medical costs. Furthermore, the ability of the elderly to chose their physician is diminishing, as the number of doctors willing to accept assignment under the medicare program is steadily declining.

In my view, Mr. Chairman, we must begin to reform the medicare program now, so we can pay for benefits for the elderly of tomorrow.

Restructuring the current incentives is imperative. We must begin to replace the incentive to overserve with one that emphasizes outpatient and home health care, and reduces unnecessary hospitalization and utilization. We must begin to reverse the incentives that, if left unchecked, will strain the Hi trust fund past its breaking point.

In my view, the CHAMP bill, S. 1509, represents vital first step in reforming the medicare program. It will not solve all of the problems faced by the elderly and the Hi trust fund, nor, is it intended to, but it is critically important that we begin to address these issues. This is a significant first step that we can take to save money without sacrificing one bit of quality health care.

Mr. Chairman, yesterday the Aging Committee held a hearing to examine the benefits that accrue to medicare beneficiaries enrolled in prepaid plans, and to look at differences in physician treatment of elderly in prepaid plans versus the fee-for-service system.

The testimony heard by that committee indicates that reforming medicare as proposed by the CHAMP bill is quite promising for the beneficiary. Beneficiaries themselves told us that such a reform eliminates cumbersome, frequently overwhelming claims reimbursement paperwork. Because these prepaid plans offer a continuum of care, they eliminate much of the bewilderment associated with seeking to find physicians, lab, X-ray, home health, and other services that medicare will cover. And, under a prepayment arrangement, the elderly are able to budget their out-of-pocket health care expenses.

And physicians told us that, under a prepayment mechanism, they are more cognizant of appropriateness of care, home and community resources to expedite hospital discharges, and overall utilization of services.

From the CMP's perspective, reforming medicare as proposed by the CHAMP bill, and as is being tested in a number of HCFA-sponsored demonstrations, enables CMP's to serve medicare beneficiaries in the same way that they do business with their under 65 enrollees. We are learning from the demonstrations that in addition to the tremendous benefits that can be realized by the elderly, there are some problems that need be addressed.

Today's hearing provides us with the forum to explore these matters. I look forward to hearing from our witnesses today as we examine this important issue.

Senator DURENBERGER. I am pleased that we could have this hearing today. No, I am not really pleased we are having a hearing today, but I am pleased that we are having this hearing.

The Congress has nearly completed work on an extremely hectic and historic effort in reducing the size of the Federal budget in the 1981 Reconciliation Act, expected to gain final House and Senate approval tomorrow.

It will reduce for fiscal 1982 in medicare and medicaid spending by $2.5 billion. Under the final bill, medicare beneficiaries, hospitals, physicians, and other providers of health services all will pay more and will be reimbursed less in fiscal year 1982.

Yet reconciliation did not change the reimbursement system under which we have operated for the past 16 years—the system which has contributed 18 percent annual increases in our Federal outlays for medicare and medicaid.

Unless we change the system, we will be forced into the same wrenching process year after year.

The approach to system reform that many of us favor is to stimulate competition in the health care system. I should point out that competition as far as I am concerned, is not a piece of legislation but a strategy.

One portion of that strategy is to encourage alternative delivery systems such as HMO, whose ability to set premiums prospectively is attractive to those who are concerned about the unpredictable and unrestrainable increases in health care costs.

Today's hearing will focus on prospective reimbursement mechanisms for medicare and medicaid, which as the largest payers of health services are driving forces in health inflation.

I expect that we will hear both the good and the bad news about prospective reimbursement. We won't hear all of the news. And I see this as a first step in the subcommittee's task of gathering information on how various reimbursement methods work and how they might work better.

I would like to remind the witnesses that due to the very limited time available today, you are requested to limit your remarks to the time that has been allotted. And that your complete written statements will be made part of the record.

We will start with Dr. James F. Donovan, Associate Administrator for Budget, Management, and Support Services of HCFA, accompanied by James Kaple, Acting Director, Office of Research Demonstrations and Statistics of HCFA.

Dr. Donovan, you may proceed.

STATEMENT OF DR. JAMES F. DONOVAN, ASSOCIATE ADMINISTRATOR FOR BUDGET, MANAGEMENT, AND SUPPORT SERVICES, HEALTH CARE FINANCING ADMINISTRATION, ACCOMPANIED BY DR. JAMES KAPLE, ACTING DIRECTOR, OFFICE OF RESEARCH, DEMONSTRATIONS AND STATISTICS, HEALTH CARE FINANCING ADMINISTRATION

Dr. DONOVAN. Thank you, Mr. Chairman.

As you indicated, Dr. Kaple is with me to answer any technical questions you might have regarding the research and demonstration projects that are presently underway relative to HMO's.

We are pleased to be here to discuss with you these issues. We have submitted our testimony and would appreciate that it become part of the record.

I would like to briefly, in six points, summarize that testimony.

We share with you, Mr. Chairman, and members of this subcommittee, an interest in fostering a better relationship between our beneficiaries and providers of prepaid care.

The concept of prepayment of HMO's is totally in concert with the administration's competitive approach to health care delivery.

Neither HMO's nor medicare beneficiaries find enrollment inducements under the current reimbursement alternatives.

HCFA has approved five HMO demonstrations in order to test ways to alter incentives and increase medicare involvement in HMO's.

Early findings from these demonstrations show that medicare beneficiaries do enroll in HMO's when attractive benefit packages featuring additional services are offered, and HMO's are willing to contract to enroll medicare beneficiaries if current cost and risk reimbursement procedures are modified.

A HCFA study of three of the demonstrations shows indications of favorable selection at two of the sites. In response, HCFA has formed a work group to study the approach being used to cap payments to HMO's.

The department and the Senate have proposed giving State medicaid programs greater flexibility in contracting with prepaid plans.

Those six items summarize our prepared and submitted testimony. And we are prepared to try to respond to any questions you might have, Mr. Chairman.

Senator DURENBERGER. OK, let's talk first about adverse selection, which I assume we will hear more about during the course of this afternoon.

Can you describe briefly what your impression is of what has been demonstrated to date and what suggestions you might have for addressing the problem.

Dr. DONOVAN. There has been some preliminary information regarding that. And I will let Dr. Kaple respond to that relative to the information we found—preliminary information—on these first three demonstration projects.

Dr. KAPLE. I would point out, Mr. Chairman, that what I will discuss is evidence from three of the demonstration sites, Kaiser, Fallon, and Marshfield.

Those are the only sites that we have had in operation long enough to assess what we call the adverse or favorable selection depending on your vantage point.

In two of those sites, Kaiser and Fallon, we found that preenrollment utilization by the medicare beneficiaries that chose to join those HMO's was approximately 20 percent lower than for the beneficiaries that did not join the HMO's in these experimental sites.

In one site, Marshfield, we found that preenrollment utilization was 5 percent higher for those who chose to enroll.

So, in summary, the data we have on those three sites is mixed. And there is evidence on both sides that preenrollment utilization is not always identical for those who enroll and those who do not enroll.

We have not assessed the information from the other experiments. They have not been in place long enough, but we do have an evaluation plan to do that.

Senator DURENBERGER. Is there a reason for the distinction between the Marshfield experience and the other two that you have been able to find?

Dr. KAPLE. It is difficult to give you a definitive answer at this point, because our evaluations are not complete.

There are some hypotheses about why Marshfield preenrollment utilization patterns may be different.

I am reluctant to draw definitive conclusions at this time. Again, as I said, the empirical evidence is not all in.

Senator DURENBERGER. What kind of questions would you suggest I ask the people from Marshfield when they testify?

Dr. KAPLE. I am sure that they have some ideas about what they would like to tell you. And I would not presume to speak for them in terms of what they think is important.

Senator DURENBERGER. Let me ask either of you what the demonstrations show about the locking in or the provision that HMO enrollees must receive all of their services except emergencies through the HMO?

Dr. KAPLE. That issue is one that is only important in a risk-based reimbursement system. The demonstrations that we have in place and the bill that are being considered to modify medicare reimbursement would require a lock in. It is permitted that the HMO's pay, if they wish, for the costs for delivering care outside their setting under the fixed capitated rate.

If the beneficiary chooses to go outside the HMO and seek his care, there is no requirement that the HMO stand for that care and pay for it.

But they are at risk, and in the case of the demonstration with Kaiser, those beneficiaries that went out of plan, I think there is an education process here. When they go out of plan, Kaiser chose for public relations purposes, I think, and for the beneficiaries benefit, to reimburse for that first occurrence of service out of plan. They coupled with that an education program that told the beneficiary that he had agreed to lock himself into service within the area.

And to my knowledge, there have been very, very few cases of repetition of out-of-plan utilization by those beneficiaries after that

initial case. So I think it is primarily a learning process for people that enroll in HMO's.

Senator DURENBERGER. Somewhere in the statement I recall, Dr. Donovan, a reference to the inflexibility of the AAPCC. Is it reasonable for us to assume that one formula can apply to all HMO's. And if not, is there a recommendation as to how to deal with that issue?

Dr. DONOVAN. Jim is the expert on AAPCC.

Dr. KAPLE. The question of whether or not one formula can apply to all HMO's—I would phrase the question a little bit different. Can one formula apply to the setting of rates for all medicare beneficiaries? The AAPCC is not calculated strictly on data from an HMO. It is calculated based upon the experience within individual counties with our medicare population, and then adjusted for the demographic characteristics of the HMO and the county fee-for-service population.

We have seen from the AAPCC results to date in looking at the way it effects reimbursement, that there may be room for improvement in the calculation or the setting of that rate.

We are looking at such things as health status adjustment. We are concerned that we not develop a system that is so unwieldy and difficult to operate that it would not be easily administrable. And we are looking at our current administrative records to determine if there are not proxies or surrogates for health status indicators that can be used to fine tune the AAPCC.

I am reasonably optimistic that those proxies can be found and introduced into that rate-setting process. And even with what we have at this point in time, we have had panels of experts and actuaries come in and review that system of establishing a rate. And their results were unanimous that it is the best available at this point in time. There is room for improvement, and indeed, we have a work plan to look at ways to improve it.

I think the bottom line answer to your question is it is the best available. I think it is satisfactory for the HMO's.

Senator DURENBERGER. And what about the 95 percent? Is it a little too early to make judgments on 95 rather than on some other percentage? And could you remind me again, because I forgot, why we picked 95 percent?

Dr. DONOVAN. I think you picked it with good reason. At the 95-percent level, it will indeed, we feel, alleviate many current concerns of HMO's. And in order for medicare to achieve savings, by contracting with HMO's, the reimbursement must be at a level obviously lower than the fee-for-service sector.

If that number is changed to some other figure like 90 percent, without a conversion limitation, then we feel we will witness a decreased enrollment as opposed to what would happen at the 95-percent level.

The growth would be slower in the enrollment process, and there would be less incentive for the HMO's to enter the business. And I think that was the reason for the selection of the 95 percent.

Senator DURENBERGER. The testimony that you gave focused on the demonstration projects and I am curious to know whether or not Nick was looking at something other than demonstrations in the area of health care financing.

We have spent the last 3 days when we weren't voting on the tax bill, in the hearing that I chaired on alternative public service delivery system. And a lot of the talk was about user fees or about vouchers, or about a variety of ways to get people into a system. And one of the areas that we struggle the most with is what do you do for those who are economically disadvantaged. Of course the voucher approach has been around for a while. Are you looking for other means to finance medicare and medicaid access to the system?

Dr. KAPLE. Yes; the question as asked is fairly broad, and I am not sure if you want me to respond to some alternative reimbursement methods such as prospective reimbursement for certain sectors of the industry like the institutional providers and hospitals and State rate setting. Or if you want to talk specifically about——

Senator DURENBERGER. I want you to get into the beneficiary of medicare, the entitled person, and find out if there are other ways or other approaches that you might be thinking about other than the kinds of approaches that have been demonstrated in these four demos we are going to hear about today.

Dr. KAPLE. We have done some things in the prevention area and the educational area in our demonstration projects where we have provided both medicare and medicaid beneficiaries with information on when it is appropriate to seek medical assistance and in what instances, and what good self-help care prevention is and how it should be implemented. Those demonstrations have been in place now for about 1 year. And the evaluation results will be coming in very soon so if that is what you are referring to, indeed, we have done some education prevention-type demonstrations with that population.

Senator DURENBERGER. Well, let's go back to the prospective, then, and tell me if you are looking at any other ways to do prospective reimbursement other than the ones we are going to hear from.

Anything else?

Dr. KAPLE. No; I believe that the prospective rate setting activity where we link in with State agencies in most instances, and the approach to capitated demonstrations we are talking about here are the basic reimbursement reform approaches that we have been looking at.

Senator DURENBERGER. What kind of waivers of the kind we are going to hear about from the Rochester area hospital people is the Department involved with? And are you actively seeking out innovative methods of prospective reimbursement?

Dr. KAPLE. There are two waiver authorities in general that we work with. One for the medicare and one for the medicaid programs. And both of these are to permit demonstrations to test more efficient and effective ways to pay for care for our beneficiaries. Those are the waiver authorities that are employed as we do the prospective ratesetting demonstrations that you spoke of. Those are also the same basic authorities that are employed as we do the capitation demonstrations with HMO's and other risk-sharing arrangements.

Senator DURENBERGER. I think this will probably be my last question. I just don't want to keep you all too long.

You talked to me a little about marketing, and the role that marketing plays in the accepting of these demonstrations.

I could make my own judgments about some of the marketing practices I have seen out there, and they haven't been all that great, at least by comparison with the marketing I had seen by HMO's going into employment settings.

But tell me just what you have seen in that whole area of how you get people interested in giving up their good, old family doctor that they have had for umpteen years and trying some other kind of experience.

Dr. KAPLE. I think the big single response to that is incentives. What are the incentives that an HMO can offer, or any organization can offer, to induce medicare or medicaid or other beneficiaries to join?

Under the current reimbursement systems for medicare, HMO's have little opportunity to offer incentives to medicare beneficiaries to join the program. The medicare beneficiary is still responsible for paying a monthly premium that is equivalent actuarially to the coinsurance and deductible. And the benefit package is the basic medicare benefit plan.

In the demonstrations, we have seen HMO's with the new reimbursement arrangements that are in place be able to offer expanded benefits to those medicare beneficiaries and, in several instances, not only offer expanded benefits but be able to reduce or, in one instance, eliminate the coinsurance and deductible equivalent on a monthly premium basis.

Those appear to be the very real incentives that medicare beneficiaries respond to. And when those incentives are made known through advertising campaigns, the use of public media television and newspapers, medicare beneficiaries do respond.

With respect to the medicaid population, the same experience is being borne out that if you offer some incentives, medicaid beneficiaries will make the choice to lock themselves into a capitated, prepaid delivery system.

In Massachusetts, we have a case-management system for medicaid beneficiaries which actually pays a cash incentive to the medicaid-eligible individual in exchange for his agreement to lock himself into the case-management system.

We have another demonstration that is just being launched in California that will test the capacity of the extended eligibility for a medicaid individual to bring them in and encourage them to join an HMO delivery system.

So, I think the bottom line is incentives. When the incentives are right, we have seen beneficiaries willing to make those choices, able to make those choices.

Senator DURENBERGER. I hear what you are saying on incentive. But the incentive is, What is in it for me besides quality health care? When I am talking about marketing, I am talking about how do you let them know that that incentive is there and it is in their better interest to do it.

And I am just talking about the advertising and the way that programs are laid out. Have you dug into that side of it so that you can share some of it?

Dr. DONOVAN. We have had some experience with both medicare and medicaid populations in this regard, and we have found that, for instance, literature and marketing approach in the welfare offices for medicaid beneficiaries does indeed work.

We have some experiences with mailings and other types of advertising in direct-marketing approaches to medicare populations, and it does indeed have an impact on a number of enrollees. And we have evidence from a number of the demonstration projects to support that.

So direct marketing, as though you were selling any other product, does indeed make a difference.

Senator DURENBERGER. Does it make a particular difference for—I think the way I prefaced my question was by implication giving up the good, old family doctor that we are talking about medicare.

What about medicaid? Is there a sense of I will go where you tell me to go, but for others the sense of the right to choose where to go? It is a very different kind of population from medicare with a very different kind of need. In many cases, they have other people whose interests they are trying to protect.

Are there differences in the marketing approach to the medicaid population?

Dr. DONOVAN. Very much so, mainly because of eligibility differences. The medicaid population eligibility comes and goes. The medicare is more stable and the marketing approach can be more directed and pinpointed than you can to a medicaid population.

But, in spite of that, we have had some success with medicaid enrollees in a direct marketing basis in the welfare office which is about the only place we could identify where to contact them. That is part of the problem. Medicare people, again, are spread through the population and responsive to general marketing approaches that everyone else uses in industry.

Senator DURENBERGER. I have other questions, but for the sake of time we are going to keep moving along. And I appreciate the testimony of both of you.

[Mr. Donovan's prepared statement follows:]

PREPARED STATEMENT OF JAMES F. DONOVAN, M.D., ASSOCIATE ADMINISTRATOR FOR BUDGET, MANAGEMENT, AND SUPPORT SERVICES, HEALTH CARE FINANCING ADMINISTRATION

SUMMARY

The Department shares with the subcommittee an interest in encouraging greater use of HMO's by the medicare population.

Neither HMO's nor medicare beneficiaries find enrollment inducements under the current reimbursement alternatives.

HCFA has approved five HMO demonstrations in order to test ways to alter incentives and increase medicare enrollment in HMO's.

Early findings from the demonstrations show that: Medicare beneficiaries do enroll in HMO's when attractive benefit packages featuring additional services are offered; HMO's are willing to contract to enroll medicare beneficiaries if current cost and risk reimbursement procedures are modified.

A HCFA study of three of the demonstrations shows indications of favorable selection at two of the sites. In response, HCFA has formed a work group to study the approach being used to cap payments to HMO's.

The Department and the Senate have proposed giving State medicaid programs greater flexibility in contracting with prepaid plans.

STATEMENT

Mr. Chairman, members of the subcommittee: I am Dr. James F. Donovan, Associate Administrator for Budget, Management, and Support Services, for the Health Care Financing Administration. I am accompanied by Dr. James M. Kaple, Acting Director of the Office of Research, Demonstrations and Statistics. Dr. Kaple is here to answer any technical questions you may have relative to the ongoing demonstration projects, including what preliminary data is showing us about reimbursement to HMO's. I would also like to point out that my own experience in the private sector in developing HMO's and delivering health care on a capitated rate basis makes this an area of personal interest to me.

We are pleased to be here today to discuss a number of issues that affect medicare and medicaid contracting with HMO's and other prepaid entities. We share with you, Mr. Chairman, and members of the subcommittee an interest in fostering a better relationship between our beneficiaries and the providers of prepaid care. The concept of prepayment of HMO's is totally in concert with the administration's competitive approach to health care delivery.

Background

In the early 1970's, a number of interested parties viewed HMO's as the alternative to the traditional fee-for-service provider community. Advocates made many claims on their behalf, with most emphasizing the ability of the HMO to reduce the cost of hospital care. Prepaid plans were viewed even more favorably as the inflationary trends in health care expenditures began to have an impact on key decisionmakers. From the perspective of cost containment, they became critical.

Congress, in the Social Security Amendments of 1972, provided for an HMO payment mechanism that it felt would enable medicare to do business more readily with these relatively new provider systems. It made available, as you know, two methods of reimbursement: A cost option and a risk approach. While we have spent much time over the last few years discussing with you the merits of various reimbursement schemes, I believe that there is general agreement on one thing: The current system is not working. Only about 2.5 percent of our medicare beneficiaries are HMO members. Or, to put it another way, less than half of the HMO's that could contract with medicare have chosen to do so. The reasons for this are varied and, I believe, not as simple as some of use would have liked to believe.

Reimbursement

Many claim that the reason for this lack of interest lies solely in the reimbursement alternatives. The cost approach, under which HMO's are reimbursed their reasonable costs, does not conform with the prospective nature of HMO financing. Instead of rewarding efficiency, we pay for whatever costs are incurred. Similarly, even risk contracts involve cost settlement. HMO's do not know their per capita revenues until the close of a contract period even though they receive interim payments throughout. The result is that no HMO now has the opportunity to deliver services to its medicare enrollees in accordance with the financing principles used for the rest of its population.

Enrollment incentives

If we accept the premise that one of the primary incentives for people to enroll in HMO's is better coverage, then there is no such motivating factor for our beneficiaries under current authority. By choosing a more efficient delivery mechanism, they do not gain by receipt of additional benefits under either a cost or risk contract. While there may be other factors encouraging HMO enrollment, such as access to an continuity of care, these may be less important to the elderly who already have established doctor-patient relationships.

Demonstrations

Because so few medicare beneficiaries have enrolled in HMO's, we have had little good information available on why both parties have not been more interested in each other. With that in mind, in May 1978, we released a request for proposals (RFP) in order to test ways to alter incentives and increase medicare enrollment in HMO's.

As a result of this RFP, we signed demonstration contracts with seven organizations. Five were approved to enter the operational phase: Kaiser-Portland (Oreg.); Marshfield Medical Foundation (Marshfield, Wis.); Fallon Community Health Plan (Worcester, Mass.); Interstudy (Minneapolis/St. Paul, Minn.); and Health Central (Lansing, Mich.).

These contracts had two phases. In phase I, which lasted approximately 18 months, the HMO's developed a detailed demonstration protocol. After HCFA approved the protocol, four sites initiated a three-year implementation phase. Three of

these—Kaiser, Marshfield, and Fallon—have been in operation for about a year and a half. Interstudy, which is acting as a broker for four HMO's, began an open enrollment period on May 1, although one participating HMO was permitted to begin enrollment in January. One site, Health Central, which will involve both medicare and medicaid beneficiaries, will enter Phase II this summer.

With each of these projects, our goal is to test the capacity of HMO's to reduce costs to the medicare program, and the beneficiary's willingness to "lock in" to an HMO if the incentives are right.

In each demonstration there is at least a 30-day open enrollment period; there is some benefit expansion or reduced coinsurance and deductible in order to encourage medicare enrollment; reimbursement is capped by the adjusted average per capita cost (AAPCC). The AAPCC is the average cost that would be paid for providing medicare services to the HMO enrollees in the fee-for-service sector. It is actuarially adjusted to reflect the demographic characteristics of the HMO's medicare enrollment.

Findings

While it is much too early to arrive at definitive conclusions about these demonstrations, I would nevertheless like to share our preliminary findings with you.

If benefit packages are attractive, medicare beneficiaries do enroll in HMO's. Over 25,000 beneficiaries—which represents over 30 percent of all beneficiaries under risk and cost contracts—have enrolled at the four sites where HMO's are offering benefits in addition to the regular medicare package. These extra benefits include a number of services such as eyeglasses, hearing aids, reduced premiums, and unlimited hospital days.

More than 80 percent of these beneficiaries, or 21,000 individuals, enrolled through open enrollment rather than through conversion from their existing affiliation with the HMO.

HMO's are more willing to contract with HCFA to enroll medicare beneficiaries if current risk and cost reimbursement procedures are modified.

HMO's without extensive medicare experience find it more difficult to estimate accurately hospital utilization than do those with prior medicare experience.

One of the most controversial issues surrounding our demonstrations is one that has not lent itself to any easy answers throughout the HMO movement. That is: to what extent does favorable or adverse selection occur during the enrollment process; and, to the extent that it does occur, how does one accurately set a payment level for HMO's? Favorable selection, of course, happens when persons with better than average health status enroll in the HMO. The opposite results in adverse selection. Under our demonstrations, favorable selection would take place when the risk of incurring medical expenses by the enrolled group is less than predicted by the AAPCC. When it is greater than predicted, adverse selection would occur.

We have done in-house a study of our first three projects—Fallon, Marshfield, and Kaiser—to determine the risk status of the enrolled beneficiaries compared to the general medicare population in the HMO's service area. Our preliminary findings show evidence of a favorable selection bias among medicare enrollees at two of the HMO's: Fallon and Kaiser. While we are in the process of confirming these results, they do give us some concern about the accuracy and sensitivity of the methodology for calculating the AAPCC. For that reason, we have formed a work group to address any imperfections that may occur when we adjust for the differences between HMO enrollees and the fee-for-service population. This group will study and offer whatever recommendations may be needed for finetuning the AAPCC. At the same time we also have to learn more about HMO enrollment. We have to learn to what degree the HMO's own enrollment procedures may be contributing to a selection bias and to what extent healthier individuals self-selected in the HMO demonstration sites. We will be carefully assessing the open enrollment procedures of our demonstrations to determine their impact on this finding.

Medicaid

Before I close, I would like to say a few words about medicaid and HMO's. We were pleased that the Senate in its reconciliation bill chose to lift restrictions limiting States' flexibility to reimburse on a risk basis. We had also proposed this repeal. With this change, States could contract with any number of cost efficient entities, in addition to qualified HMO's. In the past, organizations other than qualified plans have been precluded, except for limited exceptions, from entering into prepaid risk arrangements with State medicaid programs. If this change is enacted, HMO's, other prepaid plans, and State agencies will have a freer hand to enter into more satisfactory arrangements than currently exist.

Concluding remarks

Let me conclude by saying that this administration believes that HMO's are an important alternative to the fee-for-service system. In its attempts to control health care costs and foster the efficient, and competitive, delivery of health services, the administration believes that the role of prepaid care will be critical. Consistent with this challenge, we are supportive of efforts to enroll more beneficiaries in HMO's. Despite some unanswered questions about how they achieve their economies, we do know that HMO's have a consistent track record of experiencing lower per capita hospital costs. We do know that given the right circumstances, our beneficiaries will sever long-established patterns of receiving care and enroll in these innovative and more comprehensive delivery systems. I would just like to reiterate in closing that the current reimbursement options do not serve either the beneficiary, the Government or the HMO well. In response, we are constantly working to develop new approaches to the financing of health care that are efficient and competitive and that will, indeed, contain the rising cost of health care.

Mr. Chairman, that concludes my remarks. I will be happy to answer any questions you may have.

Senator DURENBERGER. Our next panel consists of Dr. James Reynolds, Medcenter Health Plan, Minneapolis, Minn., Dr. Russell Lewis, medical director of the Greater Marshfield Community Health Plan, Marshfield, Wis., John P. O'Connell, executive director, Fallon Community Health Plan, Worcester, Mass., and Merwyn Greenlick, Director, Health Services Research Center, Kaiser Foundation Health Plan, Portland, Oreg.

You may proceed in the order listed, or in any other order that you wish.

STATEMENT OF DR. JAMES REYNOLDS, MEDCENTER HEALTH PLAN, MINNEAPOLIS, MINN.

Dr. REYNOLDS. Mr. Chairman, my name is Dr. James Reynolds. I am a specialist in internal medicine at the St. Louis Park Medical Center, a 140-member multispecialty group practice in southwest Minneapolis.

We are a fee-for-service clinic since 1972, and have sponsored the Medcenter Health Plan, an HMO organization offering prepaid care to employee groups, with a current enrollment of over 80,000 patients.

Appearing with me on the panel are representatives of three other HMO organizations, Mr. John O'Connell of the Fallon Community Health Plan, Worcester, Mass., Dr. Russell Lewis of the Greater Marshfield Community Health Plan, Marshfield, Wis., and Dr. Greenlick of the Kaiser Foundation, Portland, Oreg.

Our four organizations, plus three other Twin City HMO groups have recently become involved in medicare demonstration projects in which we have agreed to deliver to the medicare population a designed set of benefits for a predetermined, prospectively paid fee.

The benefits amount to a comprehensive health care package which for the most part exceeds present medicare fee-for-service entitlements.

The financial risk becomes our burden. This is also the first time in the history of the medicare program that this type of arrangement has been attempted between the Federal Government and HMO organizations.

Our success to date, with our nonmedicare HMO population, leaves us to believe that the same principles are applicable to the care of the elderly, although admittedly it is a much more complex problem.

It is premature to report on the Twin Cities experience, since we have only begun, but we will briefly categorize a few observations.

First, adverse risk selection was and still is a major concern of our clinic.

Second, negotiation in dialog with representatives of HCFA has been arduous and, in some respects, counterproductive to our cost control methodology.

Third, to date enrollment's experience has not met our expectations, again, we are early in the program.

Fourth, and finally an upbeat note from a professional point of view especially, our participation in the program has been a project that has raised our sensitivity and understanding of the care of the older population group.

Our organized response can only translate to their better care in the future.

I would like to yield to the other members of the group, all of whom have statements. And I want to acknowledge—excuse me, I thought there was another member of the panel.

We will be available for questions after the other statements.

Senator DURENBERGER. Thank you.

STATEMENT OF DR. RUSSELL LEWIS, MEDICAL DIRECTOR, GREATER MARSHFIELD COMMUNITY HEALTH PLAN, MARSHFIELD, WIS.

Dr. LEWIS. Mr. Chairman, we appreciate this opportunity to discuss our experience with prepaid risk contracting under the medicaid demonstration program.

I am Dr. Russell Lewis, medical director of the Greater Marshfield Community Health Plan. I am also a practicing physician with the Marshfield Clinic in Marshfield, Wis., a 185 physician, multispecialty group practice.

The Marshfield Health Plan with a medicare demonstration program and its regular program for under age 65 serve 68,000 members of our community.

It represents 35 percent of the Marshfield Clinic's business. The other 65 percent being traditional fee-for-service.

As a summary statement I would like to make the following points.

First, the Greater Marshfield Health Plan entered medicare demonstration program in an attempt to provide access to prepaid health care for the 22,000 area medicare beneficiaries.

Second, the medicare demonstration at Marshfield has been offered on a continuous open enrollment basis, with special marketing efforts to the institutional and chronic renal beneficiaries.

Third, marketing of the demonstration has been very successful. To date we have enrolled 8,500 or over 37 percent of the area medicare beneficiaries.

Fourth, there are strong indications that adverse selectivity in enrollment and better financial access for the medicare beneficiaries have caused significantly higher service utilization than would be expected by the average area medicare beneficiary.

Fifth, major financial losses have been incurred in the medicare demonstration program.

Sixth, Greater Marshfield wishes to continue the research and demonstration programs to assist movement toward a competitive health care system. We feel the Government will benefit from continuing to transfer risk to the provider community.

Presently, the medicare patients are benefiting from the elimination of the maze of paperwork associated with obtaining reimbursement in the medicare fee-for-service environment.

Continuation of our demonstration will not be possible unless some provision is made to consider our financial experience with the enrolled population.

Both the AAPCC and ACR must be continually improved in order to reward true efficiencies and protect the trust fund.

We feel additional flexibility in setting reimbursement rates should be introduced to provide for those instances where actual experience is not reflected in the AAPCC.

We would hope that some solution can be supplied for Marshfield, at least on a temporary basis until more information is in so we may continue with the demonstration program.

Thank you.

Senator DURENBERGER. Thank you.

STATEMENT OF JOHN P. O'CONNELL, EXECUTIVE DIRECTOR, FALLON COMMUNITY HEALTH PLAN, WORCESTER, MASS.

Mr. O'CONNELL. I am John P. O'Connell, executive director of the Fallon Community Health Plan in Worcester, Mass.

The Fallon community health plan is a federally qualified health maintenance organization. It is jointly sponsored by the Fallon Clinic and Blue Cross of Massachusetts.

Worcester has about 175,000 residents and there are about the same number in the immediate environs that make up the Fallon community health plan service area.

We are a one group "Group Model Health Maintenance Organization." All services to plan members except for emergencies are either provided by or arranged by the physicians of the Fallon Clinic. The Fallon Clinic has existed in Worcester for over 50 years.

It has 65 full-time physicians practicing at three large modern clinic sites.

In 4½ years of operation, the plan has grown to cover 34,000 persons including 5,600 senior plan members enrolled under our experimental plan.

At a time when our total membership was only 5,000, we responded to a HCFA request for proposal. At the time we had no existing program for persons over 65 years of age.

We proposed to make available to medicare beneficiaries, in our service area, a comprehensive set of benefits in lieu of traditional medicare coverage.

These benefits were to include all covered part A and B services, all deductible and coinsurance items, preventive services, refractions, eyeglasses, and prescription drugs subject to a $1 copayment charge.

We enrolled 3,600 members in year 1 of the program and in year 2 that number increased to 5,600.

In entering into this program, we hoped to demonstrate certain things. First, that a plan such as this plan will lead to increased receptiveness by qualified HMO's to enroll medicare beneficiaries.

We think the experiment has been good for us. It supplied members and a secure cash flow at a crucial time in our development. Finances are very tight, but nevertheless successful.

Second, that the plan is cost effective. The Government is saving 5 percent on the cost of covered part A and B services. The value of benefits in addition to covered part A and B services provided each member including deductible and coinsurance items, preventive services, refractions, and prescription drugs is about $40 per month. The member pays only $7.50 for these benefits.

Third, we hope to prove that a plan such as the senior plan can attract medicare beneficiaries to enroll. We have, in fact, enrolled 10 percent of the medicare population of our area within a 1-year period.

The fourth and final thing we hoped to demonstrate was that a plan such as the senior plan can be offered successfully in a health maintenance organization of moderate size. We think we have done that.

In conclusion, we endorse the proposed legislation.

Senator DURENBERGER. Well, I am sorry Dr. Greenlick, you came all the way from Oregon. We are not going to be able hear from you because the red light is going on. [Laughter.]

No, you go ahead, and take as much time as each of the other panelists.

STATEMENT OF DR. MERWYN GREENLICK, VICE PRESIDENT, RESEARCH, KAISER FOUNDATION HOSPITAL

Dr. GREENLICK. Thank you, Mr. Chairman.

It is really a great pleasure to be here. We have been very excited to be a part of this HCFA demonstration, and we are very proud of what we believe are very favorable results.

We began the project with an objective in mind of notifying essentially every medicare beneficiary in the Portland metropolitan area that under this demonstration they would have an opportunity to join the Kaiser permanent medical care program.

From May 27, when Senator Packwood joined us in the kickoff announcement of our demonstration, we conducted a very active television, newspaper and direct contact marketing campaign to insure that the broadest representation of beneficiaries in the area would have the opportunity to join the program.

We were on television about 155 times with an interesting and dignified television announcement, making clear that the program was available to all. We ran announcements in 17 different newspapers and the project staff visited almost every senior citizen center in the area, enlisting the aid of the senior citizen advocates and the senior citizens themselves.

We enrolled our original maximum of 4,000 new medicare beneficiaries within—month the health plan increased the limitation in our system to 5,500, and in fact, we enrolled nearly 6,000 new medicare beneficiaries by the first of the year. In fact, we had the applications for that many available by the first of November. We soon gathered a waiting list that still grows, and has now about 600 people on the waiting list.

The difference between 95 percent of the AAPCC calculation in the Portland metropolitan area and the ACR that we calculated

was sufficient to offer the medicare beneficiaries the opportunity to join the Kaiser permanent medical care program without paying a monthly supplemental dues rate to cover the coinsurances and the deductibles.

The folks responded very quickly to that offer. We found, in looking at the utilization of services in the first year, that the utilization of services is running slightly higher than we projected—about 1,700 hospital days per year versus about 1,600 projected, but still very much lower than the community rate, which is around 3,000 days per 1,000 people in the Portland metropolitan area.

The doctor office visit utilization is running somewhat higher than predicted. But we are still very satisfied with this program and the folks who have joined the program are very satisfied and very excited about it. And we are learning new things about how to provide services for our geriatrics population in a very efficient and effective manner.

Senator DURENBERGER. Is there something—you talked briefly and I didn't get it all—about the offer you made these folks. Is there something different about the way people participated in the financing of your project than these other projects?

Dr. GREENLICK. Well, there are two things that were different.

In the first place, we needed to learn what would be more effective in encouraging medicare beneficiaries to join the Kaiser program. We were interested in knowing whether a zero monthly payment for the supplementary costs of medicare would be more attractive than would a relatively complicated program of supplementary benefits we tested the simple option against a choice among four options. The four-option choice included paging no premium for joining the program and having no coinsurance or deductibility; an option to spend $6 a month and for a drug prepayment, hearing aid prepayment, and a vision prepayment benefit; a third option where a $10 a month premium was charged for total dental coverage; or a fourth option with a premium of $16 a month for all of the above.

We produced very effective enrollment material which included the explanation of the four options program for half of the population, who applied and material with only the zero cost option for the other half.

We found that essentially 50 percent of the people who requested applications joined the program, whether they were offered only the zero dollar option or were offered the complex choice of additional benefits.

We feel that it is not the extra benefits that motivates beneficiaries to join. However, we also found that of the people who were offered the optional benefits in the original application, about 80 percent of the people selected one of those benefits.

Senator DURENBERGER. Eighty percent?

Dr. GREENLICK. About 80 percent.

Forty percent selected the $6 a month drug-hearing aid and vision benefit, and another 40 percent selected the $16 a month program which included full coverage.

Senator DURENBERGER. Do you come to an open enrollment period in which people can change from year to year? Is that built into the demonstration?

Dr. GREENLICK. Yes; first of all the project began open enrollment with a 6-month, open enrollment period. We enrolled on a first-come, first-serve basis. We accepted everybody that applied, regardless of health status, and without any prior health examination or health screen.

The only people that were excluded were people who were eligible for medicare on the basis of endstage renal disease.

At the first of February, we allowed people to make any change among the alternative option selections. Almost all of the people kept the alternative that they had or moved up to a more expensive alternative.

Senator DURENBERGER. That is February of this year?

Dr. GREENLICK. That is February of this year, yes.

Senator DURENBERGER. Have either of the two in the middle been in existence long enough for you to have gone through 1 year of experience——

Mr. O'CONNELL. Our project was the first project implemented. It became operational in April 1980. It continued for 2 years. And our enrollments procedures were much the same as Kaiser. We had an unlimited open enrollment for a period of 1 month each year where we selected, we accepted every member on a first-come, first-serve basis.

We solicited the entire population of our service area on a dual choice basis with Blue Cross, as they offered their med-ex coverage. So each med-ex enrollee chose either to be covered by Fallon in the experimental program or the traditional wraparound.

We advertised in the Worcester newspapers and in all of the surrounding newspapers and we found very good acceptance.

Dr. LEWIS. Yes; we became operational right after Fallon. We started enrollment in April 1980; it became effective June 1, 1980, and we have had continuous open enrollment right up until just recently because of the setbacks we have had.

Senator DURENBERGER. Your program sounds like it really went like gangbusters. It says here in the first 3 months over 6,000 medicare beneficiaries joined the health plan and represented over one-third of the entire medicare population in the service area. And since that time you have expanded to a few more counties. I mean, it really sounds terrific, except you are not making any money, right?

Dr. LEWIS. Right.

Senator DURENBERGER. I take it, and I haven't read your full testimony, but I take it there is a fair amount of adverse selection going on in that process. And I just want you to talk a little bit about the problems with the AAPCC.

Dr. LEWIS. I think a combination of all. If we had been getting the same amount of money under the AAPCC as the other plans have, we wouldn't have any financial difficulties. You see, we are getting about $75 per person per month, and that is considerably less than Mr. O'Connell just talked about $120 and I know in Minneapolis it is even more than that.

So that, I think, is one factor. Now the why's and the wherefore's of that are things that need to be studied so that—before any bill comes out—you have some appreciation of whether this is a local phenomena or whether it is a rural phenomena or just what caused this.

I think that the other thing is, we have adverse selection because of the fact that in our area there is never a question of having to change physicians. All the physicians in the areas that we have described are participating, affiliated doctors.

So all the people who have any degree of illness for the $25 and some cents that they pay each month, they are much better to enroll in the plan than to stay out of the plan because the option to go to a different physician or their old physician really doesn't exist. All the physicians are part of the program.

So from that standpoint, we obviously are attractive to the sickest people, which is what we knew, and we are happy to do that.

We also had quite a waiting list of people who postpone nonemergency medical care. That is one of the things that we are interested in developing too, is the utilization going to fall now that most of those initial things have taken place.

We thought it would show up by now, but it really hasn't been demonstrated to date.

Senator DURENBERGER. Have you had time to give some thought to how we might adjust the AAPCC as a formula or use some other kind of a formula?

I know that yesterday, during the hearings, there was some conversation about need to add health status to the normal age, sex.

Dr. LEWIS. No; we would be very happy to cooperate with the people in Washington that are looking at this. I don't think we would come in with any concrete proposal as to how to change this at the present time. There has to be some exceptions made first.

Senator DURENBERGER. I think, and I may be missing the point, but it seems to me you wouldn't be changing it for everybody else, but you do have, at least in this, you have a unique situation.

Dr. LEWIS. Yes; I think you have to look at the experience in the area.

Senator DURENBERGER. Right.

Dr. LEWIS. I think the Secretary, whoever makes that final decision, should be looking at the enrolled prepaid experience. It doesn't show, in the AAPCC for us.

Dr. GREENLICK. We certainly do feel that adding health status provides an important missing link in fine-tuning the AAPCC.

We think the demonstrations are, in fact, providing the data that is needed, as Dr. Kaple said earlier, to make it possible to fine tune those calculations. We think it is possible to do within the time frame of the next year.

We are quite confident that while there are certain problems right now, it would be fairly easy to straighten those problems out.

Senator DURENBERGER. I have to make sure I dump on Jim here, because everybody else says they have such terrific enrollment; everybody is just beating a path to the doors. For the first time in recent competition history, Twin Cities are not showing great numbers.

I know you talked about the arduous requirements in dealing with HCFA. I know this is somewhat different because of trying to involve a number of HMO's in the project.

I wish though, for us, for our benefit, you would talk about the problems you had during the—if you are familiar with them, during the development days, some of the administrative inflexibilities and the lack of understanding by the Government.

My mail is full of that sort of a thing in other areas. How would you apply that to the specific problems you had there?

Dr. REYNOLDS. I guess it really makes me feel put on a spot, Senator. I was not involved with those negotiations, our administrative people were. My report is prepared by our administrative people.

I know one of the very original problems was this concern about risk exposure. That was finally addressed by our being allowed to use a health questionnaire to screen or health screen questionnaire, to screen patients coming in to the program.

To date, that has amounted to 15 to 20 percent of the people being rejected for the plan because of their prior health experience.

So, that is addressing again, that one question that you have already asked.

The other negotiating difficulties, in the beginning, I am not that familiar with. I understand they are still ongoing, especially now that we are into the operational phase and the philosophy that I have been told is that HCFA comes at it from a different sense, looking at things from a fee-for-service reimbursement mechanism; whereas, we are looking at it from a prepayment mechanism.

We have our philosophy and our methodology in place and the two tend to conflict. I think there are some examples in that written statement that addresses that very problem.

Senator DURENBERGER. I will save some of those administrative inflexibility questions for Dr. Ellwood, when we get to him. I am sure he will speak clearly as to those.

While we are on the Twin Cities, do you have any idea to what extent all of the competition that is out there in the Twin Cities right now might have impacted on the medicare enrollment process?

Dr. REYNOLDS. You mean on the———

Senator DURENBERGER. On the demonstration itself. Might that have been a factor?

Dr. REYNOLDS. I think the populace in general was bombarded by four different plans, all tied in with the demonstration project. There were other plans that were just being presented at the same time. I think it really created confusion in the marketplace.

I think that was one of the reasons that—why there has been a general reluctance merely feeding on a natural doubt that people have about changing from medicare to something else which is really still endorsed by the Government.

I think the other thing is their concern that this is a 3-year project. Many of them are saying, "What happens after that?" I think they feel somewhat nakedly exposed to some type of disaster at that time. I really think more enabling legislation and broadening of this entire project and making it perhaps more universally available might address itself to the particular problem.

Senator DURENBERGER. May I pick up on that latter point with each of you, because prior to the time we got on the tax bill, I was sitting up here with Bill Armstrong and others, for about 3 weeks dealing with social security. I know what you are talking about right now, at least, in terms of that sense of insecurity that people have, particularly if we are talking about a medicare population.

Jim points out that maybe the fact that this was a demonstration, this was 3 years, might be a factor in some way in his problems, but may not have been in any of the others.

Would you speak to that issue?

Dr. LEWIS. Yes; I would be happy to speak to it because I think that is one of the things that scares us the most.

We took the approach that if the contract ceased and it had been a success or even for some reason we had to abandon it along the way, we would guarantee them not having to go back to the horrible world that they lived in with medicare before so far as the paperwork and all the other things and the costs, and so forth.

So, right now, we are in a very precarious position, in our eyes, because if we can no longer continue the contract, we are going to have to figure out some other method of having our enrollees preparing their medicare part A and B services.

A lot of the people that aren't enrolled yet still have the skepticism that Dr. Reynolds has talked about. But the people that enrolled took us at our word that we would work out something for them so they would not have to go back to the unsatisfactory situation of fee-for-service medicine.

It is going to be up to us, if we lose the contract, to supply something.

Mr. O'CONNELL. I think we at the Fallon community health plan are quite exposed on not continuing the project in that we have hired doctors, expanded the clinic's base, and spent a lot of money to serve this population.

We will be looking for ways to continue the program. The membership, on the other hand, being a Blue Cross connected program, were guaranteed that in the event this experimental program should be discontinued, they would have the right to transfer to the medex 3 program, another type of comprehensive program not as good as the Fallon health plan, but, nevertheless, an option.

So that the dual choice aspects of the program are a very definite plus to us in order that we may be enrolling large numbers, up to 10 percent of our population.

Dr. LEWIS. If you will let me interrupt a minute, excuse me. We have the same agreement with the Blue Cross, but in our eyes that Blue Cross preferred still isn't adequate.

Dr. GREENLICK. We were told by the seniors' advocates that we consulted, that folks had been hustled by a lot of insurance salesmen and other folks, in the past, and that we would be facing a very skeptical population.

We spent as much time as possible in our discussions with folks and in our announcements. You see the whole middle page of the marketing brochure we send out says on the top, "Is this special program really for you—Some limitations."

We wanted to have an informed group of beneficiaries joining. The 2½-year limitation was a concern. Our program was scheduled

to end at the end of 1982—although we have asked for an extension—and that was a very important issue for some people who were going to be giving up their current health insurance.

We guaranteed all of them, at the end of the project, that they would have an option to join the standard Kaiser Foundation health plan and informed them that they would have to pay for it out of their own pockets if they did join.

But, it was, I think, a very important issue. We, too, would like to see some legislation, before the project is over, that would allow our members to continue in a very similar way.

Senator DURENBERGER. I would suppose—I was supposed to ask you about the lock in.

Dr. GREENLICK. We are not really sure that all the medicine beneficiaries have a longstanding relationship with physicians, as our American mythology talks leads us to believe.

That "old family doc" may have retired about the same time as the beneficiaries retired from their job.

However, we did find that most of the members did have some kind of satisfactory medical arrangements of one kind or another before they joined the Kaiser permanent program.

But, we also found they were very dissatisfied with the amount of paperwork, and the amount of uncertainty about the cost of these services, and that they were willing to join our program.

There were also some of them that really didn't understand the implications of the lock in. We did, in fact, experience a fair amount of nonemergency outside use of hospitalization as new members came into the program. It averaged about 20 or 25 cases a month for several months.

We did take the position—and not for public relations but for member relations purposes—that we would pay for those services in the early months of the project even though our contract allowed us not to pay for them.

We did not want beneficiaries hurt by having to pay for services that they received outside if they were legitimate medical care services, nor did we want the hospitals or the doctors in the community to be hurt by having provided services that they thought were covered under medicare.

The total cost of those outside services in the first year hasn't exactly been totaled up yet, but will run somewhere between $400,000 and $600,000. And we paid the costs.

It does distort our expense experiences in the first year. We have continued to pay them for any outside claims incurred up to the first of June of this year. We have been doing a great deal of education of our people and there were very few who used outside hospital services more than once.

Senator DURENBERGER. John, do you want to add to that?

Mr. O'CONNELL. Yes; less than 1 percent of our hospitalizations have been by accident, as far as we are concerned, to nonaffiliated hospitals.

However, even that 1 percent tends to be somewhat of a problem. We occasionally get a foreign-speaking person whose son or daughter signs them up and they truly don't understand.

It is very difficult to have to reject a claim because of this reason, but we have rejected a few. We feel that this unfortunate

situation could be avoided, if on the medicare care card it were printed, "Health Maintenance Organization Member," instead of "Part A, Hospital Insurance, Part B, Medicare Insurance."

One of the little improvements we would like to see in this arrangement is that there is some way that the health insurance identification card can properly identify the individuals as a health maintenance organization member.

Dr. GREENLICK. We found one woman who signed up was the mother of a physician in the area. She signed up without telling her son. She ended up in the hospital, admitted by her son's friends, and didn't have the courage to tell them she was a Kaiser permanent member.

After we solved it, she decided to stay on with the program anyway, in spite of what her son said. [Laughter.]

Senator DURENBERGER. I am sure we can spend the rest of the afternoon on this subject. I appreciate all four of you being here today to share your experiences with us.

As I indicated earlier, your full statements will be made a part of the record. Any additional comments that any of you might want to make, as to elaborate on those statements, may also be made a part of the record.

Thank you all for being here.

[The prepared statements follow:]

PREPARED STATEMENT OF JAMES F. REYNOLDS, M.D., DEPARTMENT OF INTERNAL MEDICINE, ST. LOUIS PARK MEDICAL CENTER, MINNEAPOLIS, MINN.

SUMMARY

I. Description of the Twin Cities' Experience

The Medicare demonstration project in the Twin Cities was originally designed to test a prospective capitation payment arrangement between Medicare and a number of health maintenance organizations. Developmental problems were encountered in negotiating with the government and with the inflexibility of the Medicare administrative system. Enrollment experience has not met our expectations, but we foresee substantial improvements as the demonstration continues.

II. MedCenter Health Plan Background and Experience

MedCenter Health Plan is a non-federally qualified group practice model HMO that began operations in 1972 under the sponsorship of the St. Louis Park Medical Center. MedCenter's original interest in the project was to develop an alternative approach for Medicare reimbursement in an HMO model and to prove that the prepaid approach to medical care can offer a wider range of benefits at a better price.

In spite of the many problems that were encountered in negotiating this contract and the lack of understanding by the government of the risk to the HMOs associated with this population, we are committed to this program.

III. St. Louis Park Medical Center's Experience

It is premature to report on our experience, but the ten-month planning process has had a major impact on our sensitivity and understanding of health care management in this area. We have experienced an evolving, systematized organization of care that will address the unique needs of the elderly.

Whether the Demonstration project expands or terminates, we have been motivated toward more intelligent use of our resources directed at care of the elderly, and in the final analysis this can only translate to more efficient, cost effective care without compromise of quality.

I. Description of the Twin Cities' Experience

The Medicare demonstration project in the Twin Cities was originally designed to test a prospective capitation payment arrangement between Medicare and a number of health maintenance organizations in the Twin Cities. The contract to develop the program was signed in September, 1978, between the Health Care Financing Administration and six local HMOs.

The reimbursement method selected for this particular demonstration pays each HMO a fixed monthly fee equal to 95% of the AAPCC for each Medicare beneficiary joining that particular HMO. By basing the premiums on some percentage of Medicare's known cost, as opposed to the HMOs' costs anticipated to service the population (the adjusted community rate approach), the Twin Cities experiment allows the HMOs to convert any operating efficiencies into additional benefits to attract more Medicare beneficiaries. In a highly competitive health care environment like the Twin Cities, such a payment arrangement serves to increase the competition, making the Twin Cities an excellent "laboratory" to examine the impact of government policies on the evolution of competition in the nation's health care system.

The developmental phase of the contract proved to be a tortuous negotiation process between the HMOs and the government. As with most negotiations, this resulted mainly from a lack of understanding on the part of the HMOs as to the policies and administrative inflexibilities under which the government operates, and a lack of understanding by the government of the extent of the HMOs' concerns about the risks associated with a high utilizing population with which they had very little experience. As a result of these misunderstandings and inflexibilities, two of the HMOs dropped out of the experiment before it became operational, while the remaining parties were forced to accept compromises which ordinarily would not be acceptable in order to operate the demonstration.

In general, the problems we encountered with the government stem from an inability to negotiate to a final decision with any single government representative or department; a certain ingrained bias, perhaps based on Medicare's cost contract experience, about the way HMOs should operate, and a significant degree of inflexibility within existing Medicare administrative systems which requires HMOs to adopt procedures not normally required under a prospective capitation arrangement.

Experience to date under the demonstration is preliminary at best. Although we have been technically operational since last September, the HMOs were not really marketing or actively soliciting enrollment until April. There are currently just

over 6,000 members enrolled in the four HMOs, half of whom were enrolled in one of the HMOs under a prior cost contract with the government.

Enrollment has not met our expectations, but we foresee substantial improvements in the future as we become more acclimated to the market and its demands. We expect that by the end of the demonstration project all four HMOs will have sizeable Medicare populations enrolled: We'll offer very attractive benefit packages and will, hopefully, be operating on a sound financial basis. In terms of whether this particular way of reimbursing HMOs is efficacious, we totally support it. We believe that within a competitive health care environment it is an excellent way to allow all parties to the contract (i.e., the federal government, the Medicare beneficiaries, and the HMOs) to be properly rewarded for their efforts.

II. MedCenter Health Plan Background and Experience

A. MedCenter Health Plan is a non-federally qualified group practice model HMO that was developed and sponsored by the St. Louis Park Medical Center. The St. Louis Park Medical Center took a lead role in prepayment in Minneapolis-St. Paul by integrating a mix of prepaid medical care into its existing fee-for-service multispecialty practice. Since MedCenter began operations in 1972, we have grown to over 82,000 members and currently have enrolled 17.4 percent of the over 471,000 Twin Cities residents receiving health care services through one of seven HMOs in the metropolitan area.

In addition to its contract with the St. Louis Park Medical Center, MedCenter also contracts with three other groups of physicians and four hospitals in the metropolitan area. There are a total of 24 primary care locations where members can choose to receive their care.

Over the past eight years, our prepaid experience within existing group practices has shown that with the proper incentives of prepayment, physicians can respond with a cost-effective delivery of high quality health care services. We would also like to emphasize that we believe it is the method of practice (group practice) that creates the cost-efficiencies.

B. MedCenter Health Plan in 1978 began investigating the opportunities for developing an alternative approach for

Medicare reimbursement in an HMO model. Working with InterStudy and several of the other Twin Cities HMOs, our interest was to prove that if given the opportunity to contract with the government in the same manner that the HMO contracts with existing employer groups we could put into effect a wider range of benefits at a better price. MedCenter was interested in expanding the benefits of prepaid care to the Medicare-eligible population. However, we did not wish to seek the necessary Federal qualification to deliver care to this particular population. Federal qualification offers no advantages to MedCenter Health Plan in the Twin Cities marketplace. Federal qualification for MedCenter would only increase administrative costs through additional reporting requirements.

C. Our intention in the original response to a HCFA Medicare alternative reimbursement request for proposal was to offer at least a Medicare level of benefits through a contract with the government that would provide incentives for more cost-effective care. Early discussions with HCFA officials indicated that waivers on existing Medicare regulations could be obtained so that we could contract with the government in the same manner as we contract with our private sector clients. We were also given assurances that HCFA's administrative systems were capable of managing such a demonstration.

Since 1978 our experience with the development and the administration of the Medicare Demonstration Project has shown that on numerous occasions HCFA had difficulty in operating outside of existing rules and regulations. Throughout the developmental phase our negotiations found us having to agree to more regulations that HCFA could not waive. Many of these regulations have added to the operating expenses of administering this program. In many cases the regulations tend to negate our cost-efficiencies and increase our risk under our full risk contract.

D. Under the terms of our contract, we receive 95 percent of the average area per capita cost (AAPCC). In turn we assume full risk for the delivery of services. There are no retroactive community rating adjustments under the terms of our contract. The AAPCC represents the costs that Medicare reimburses to providers in the area. This does not represent the actual physician charges. It is estimated that only 50 to 60 percent of the physicians in our area accept Medicare reimbursement levels as payment in

full. Therefore the AAPCC does not fully represent the actual costs of medical care being delivered to the Medicare population.

It was very important to us to obtain utilization data and the AAPCC rates from HCFA early in the development phase to permit our actuaries to assist us in developing our benefit package and rates. There were numerous lengthy delays in receiving utilization data and AAPCC rates that severely hampered developing this project on a timely schedule. Even after receiving utilization data and rates, corrections had to be made by HCFA because of errors in constructing the data.

Another concern on our part was that the AAPCC does not accurately reflect the actual level of risk of the population. The AAPCC is only based on a mix of demographic variables that include age, sex, county, and categories of aged, disabled, welfare, and institutionalized. With the AAPCC rate cell approach, a rate is established for each demographic cell.

If an average cross section of eligibles enroll based on the demographic characteristics, the composite level of the AAPCC capitation may not reflect the actual costs of care when health status is considered. In other words, the severity of illness is not factored into the capitation figures. This concern becomes even greater when smaller numbers of individuals enroll. This risk to the HMO is greatly increased.

Throughout our developmental discussions there was little room to negotiate with HCFA. In determining the low option benefit premium rate, the monthly actuarial equivalent of deductibles and coinsurance was calculated by HCFA. HCFA's calculated figure was established as a limit, and no HMO could exceed it. This method did not recognize variations in costs across HMOs and tended to eliminate competitive pricing forces.

E. It is important to understand the risk that is being assumed by MedCenter Health Plan providers. Again under our contract with HCFA we assume full risk for the care of the individuals who enroll. In developing the premium rates and benefits for our Low Option and High Option plans, assumptions were required for the expected mix of members who might enroll based on the demographics used for the AAPCC. Therefore, it is important that marketing efforts be directed to attract the appropriate cross section of individuals.

To help offset the risk of anti-selection, anyone applying for our High Option benefit plan must complete and pass a medical questionnaire screening procedure. The High Option is available twelve months per year and provides members with all Medicare benefits plus the following:

- Routine physical, hearing, and vision examinations.
- Preventive immunizations.
- Prescription drugs with a $3.50 copayment per prescription.
- Expanded hospital and skilled nursing facility coverage to 365 days per benefit period.
- All Medicare deductibles and coinsurance are covered.

Our Low Option plan is available 30 days per year and open to all eligible applicants who apply. No health screening is required. The Low Option equates more closely to the current level of Medicare benefits but still offers the advantage that deductibles and coinsurance are fully covered.

The Board of Trustees of the St. Louis Park Medical Center was originally reluctant to become involved in the Demonstration Project. The concern on the part of the Trustees was based on the result of an internal study that revealed that 50 percent of the patients sampled over age 65 who were using the Medical Center were being treated for cancer. It was apparent that the multispecialty group practice was attracting a great deal of secondary care for the over 65 population. Thus, there was concern that the prepaid Medicare program would enroll a large number of current patients at the St. Louis Park Medical Center.

F. There were several problems encountered throughout the development of the project that delayed the operational phase. A major obstacle was that HCFA required that their master-file records be updated for all Part A claims. This necessitates that claims be adjudicated and filed by each HMO in the same manner that they are processed under the current Medicare program. This procedure is in direct conflict with the manner in which we administer our prepaid programs and thus only adds to the time and costs necessary to administer this program.

There were several instances during the developmental phase when HCFA positions or policies shifted or were re-interpreted.

It became very difficult to discuss or negotiate any of the key issues because the HMOs were never exposed to the decision-makers. We were given the feeling at numerous times that there was no opportunity for negotiating.

G. It is apparent that problems exist in HCFA's management information system as seen both in the developmental phase and in the current operational phase. It seems that many of the problems are due to HCFA attempting to administer a prospective prepaid contract on a system that was designed for retrospective reimbursement.

To cite an example, as the system exists we are required to send enrollment information to HCFA when an applicant has been approved for membership so that HCFA masterfile records can be adjusted. We are only able to process this information once a month. Responses from HCFA have been running two or more weeks late. Both of these factors create unnecessarily long delays in notifying applicants of their effective dates of coverage. This creates concerns and skepticism in the minds of the applicants.

H. We have currently enrolled approximately 600 members in our MedCenter Health Plan Senior Health Assurance Program since marketing efforts began in April. Our response has been less than anticipated as a result of confusion and an abundance of information provided to the senior citizens in the Twin Cities. We are aware that our marketing efforts need to incorporate more education and more one-on-one contact with prospective individuals. Our marketing strategies are being modified to allow for a more effective approach that exposes a larger portion of the Senior citizen population to the benefits that our prepaid program has to offer.

I. We do want to point out that we are committed to this program, and we are doing everything in our power to make it work effectively. A demonstration such as this cannot be expected to develop without a host of problems. We recognize that the officials at HCFA are carrying out their regulatory functions, and conflicts and discrepencies will always exist.

Of deepest concern to us is that the Demonstration is successful and that we can move towards enacting enabling legislation such as the Champ Act of 1981 introduced by Senator Heintz that will permit these Demonstration Projects to become a standard of practice.

Our overriding request is that we be heard by those responsible for amending current statutes and also be heard by those officials responsible for regulating this program or future programs. As the government moves toward deregulation, increasing competition and shifting responsibility to the private sector, it is essential for us to discuss and describe our experience in the private sector as providers of health care services. If we, as providers of health care services to the senior citizens, are given the responsibility to provide health care on a prepaid basis, free of unnecessary regulatory requirements, we will be able to improve the level of services available to the elderly and contain the costs of that care.

III. St. Louis Park Medical Center's Experience

It is premature to report on our experience, but the ten-month planning process has had a major impact on our sensitivity and understanding of health care management in this area. We have experienced an evolving, systematized organization of care that will address the unique needs of the elderly. Whether it be the technical skill of the surgeon's knife or the problem-solving skills of the diagnostician, our professional expertise will be no less effective than in the past, but the added task for true success requires matching the problem with the appropriate solution. A "wellness promotion" philosophy permeates the planning process, superseding a simple "response to illness" readiness.

Our approach has been characterized by the assemblage of a number of diverse entities:

A. A physically identifiable SENIOR HEALTH SERVICE was created as the coordinating unit. It will be the initial point of entry for care of new patients, as well as a central focus for emergency and walk-in services. Coordination and triage function and implementation and review of nursing home and health care services will also be provided in this setting. The staff consists of primary care physicians in Family Practice and Internal Medicine, as well as geriatric nurse practitioners and support personnel. A social worker has been hired specifically to serve this area.

B. Realities impelled the development and better understanding of institutional alternatives and anticipated greater use of home care services. Contractural arrange-

ments were sought to assure ready availability of nursing home beds where needed. The very difficult problem of establishing criteria separating custodial from restorative and rehabilitative services was addressed.

C. An intensive orientation program is under way inviting each enrollee to an introductory program addressing an understanding of how to use the system intelligently. It is hoped that some of the confusion will be diminished, and the results thus far have been pleasing.

D. A hospital discharge planning process has been designed, which is felt to be key to maintaining appropriateness of hospitalization. Post-hospital care needs assessment will begin within 24 hours of admission, and a methodology has been established.

E. Quality Assurance assessment of our experiences by an internal audit mechanism has been unique to our overall operation for years and has been extended to the demonstration project.

F. Similarly, our established education programs, such as diabetic care, hypertension screening and care, coping with stress, etc., will be available through this program. New programs designed to meet the special needs of the elderly are being developed.

In conclusion, we will never be the same by reason of our decision, whether the project thrives or fails. We have been agitated and motivated to action towards a more intelligent use of our resources, and in the final analysis this can only translate to more efficient, cost effective care without compromise of quality.

STATEMENT OF DR. RUSSELL F. LEWIS,
MEDICAL DIRECTOR OF THE
GREATER MARSHFIELD COMMUNITY HEALTH PLAN

Mr. Chairman and distinguished members of the Committee, we appreciate this opportunity to discuss our experience with prepaid risk contracting under the Medicare demonstration program. I am Dr. Russell F. Lewis, Medical Director of the Greater Marshfield Community Health Plan. Accompanying me are Mr. Mike McDonald, Associate Director of Prepaid Plans and Mr. Gregory Nycz, Project Director of the Medicare demonstration program.

The Greater Marshfield Community Health Plan began as a private venture in March 1971 through the sponsorship of the Marshfield Clinic, St. Joseph's Hospital, and Blue Cross Blue Shield United of Wisconsin. Our program was designed to provide access to comprehensive health care on a prepaid basis to residents of central Wisconsin. We have always operated on a community rating basis and annually hold two 30 day open enrollment periods. During the open enrollment periods residents may join without regard to their health status. The program has no pre-existing illness restrictions nor does it utilize co-payments or deductibles. Professional medical services are delivered by the Marshfield Clinic, a 185 physician multispecialty group practice, and, through affiliation contracts with the Clinic, by all physicians practicing throughout the 6400 square mile service area. We have, since 1974, had a Community Health Center program which assists near poor residents of our service area. For the last four years we have provided prepaid medical services to AFDC Medicaid recipients. Currently we have enrolled 68,000 people representing 43% of the population of the service area.

The Plan exists through a series of contracts linking the sponsoring organizations. Federal qualification has not been sought, and until the time of the Medicare risk demonstrations the Plan had no access to prepaid contracting with the Health Care Financing Administration.

Following a 19 month planning phase, the Greater Marshfield Medicare demonstration program began marketing in April of 1980. Our objective was to develop a program that would be accessible to all Medicare beneficiaries in the service area, regardless of the beneficiaries' health, disability, or institutional status. This was to be accomplished by utilizing continuous open enrollment, and through a special marketing effort to institutional and chronic renal beneficiaries.

Because of delays in getting the program underway, and the considerable interest in the program within the community, inquiries about the program became numerous. In January, 1980, we began establishing a list of the names and addresses of interested beneficiaries. By April, over 1200 names were on the list. The Medicare demonstration program was formally announced on April 14, 1980 and its first participants were covered June 1, 1980. In the ensuing months, local meetings were held throughout the service area and a full-time enrollment office was opened at the Marshfield Clinic. A direct mailing was also conducted to all beneficiaries on our list and to all area Blue Cross Blue Shield United Medex Extended and Medex Preferred policy holders.

I would emphasize that the Medicare demonstration program was enthusiastically received by the Medicare population in our area. In the first three months, over 6000 Medicare beneficiaries joined the Health Plan. This represented over 1/3 of the entire Medicare population in the service area. Since that time, we have expanded the service area to include two more counties. This was done to respond to the interest of the Medicare population and the medical communities in these areas. We have also maintained the continuous open enrollment to ensure access to the program for all Medicare beneficiaries. At the present time, we have enrolled more than 8500 persons in the program. To date, only 116 (about 1%) have voluntarily disenrolled. (Other dis-enrollments, including death, ineligibility, or eligibility for medical

assistance bring total disenrollment to 445, or about 5%.) Another way of stating the acceptibility of this program to the beneficiary is that over 37% of the beneficiaries in the total service area, and 46% of the beneficiaries of the original area, now participate in the program. In the city of Marshfield, where the Clinic is located, over 65% of the beneficiaries have joined.

There are several reasons why this program has been so well received by the Medicare population in our area. First, we offer excellent benefits, such as unlimited hospitalization, all professional medical services including preventive services, skilled nursing care, home health services, durable medical goods, ancillary health care services, and all necessary out-of-area health services. Second, benefits are provided by all local providers. In almost all cases the beneficiary need not change provider. Third, services are provided for one monthly premium, which is all the enrollee pays -- there are no deductibles or co-payments. Finally, and most importantly to many participants, there are no confusing forms to be filled out. The patients simply show their Health Plan and Medicare cards to receive all needed services.

A very important aspect of the program is that it frees the beneficiary from the anxiety associated with financial uncertainty in dealing with payment for medical services. Because of increasing gaps between what had been paid by Medicare and their actual charges, area physicians generally do not accept assignment for professional fees for services to Medicare patients. While there is supplemental coverage available to Medicare beneficiaries for Medicare co-payments and deductibles, there is no "medi-gap" coverage of the difference between the reasonable charge determinations and actual Part B charges. As the gap between charges and allowable reimbursement has grown in recent years, so have the Medicare beneficiaries' out-of-pocket expenses. In our area, with family income lower than state averages, out-of-pocket expenses are a significant burden on the budgets of many Medicare beneficiaries. Thus, when

provided an opportunity to pay one premium which would virtually eliminate out-of-pocket costs, regardless of health care needs, the enrollees found that very attractive.

While we have managed to provide continuous access to the program for all Medicare beneficiaries in the area, the future of this program is in jeopardy. We have incurred considerable financial losses as a result of the demonstration program. In the first eight months of this fiscal year, the Medicare demonstration has resulted in a $1,149,000 loss to the Health Plan. The Marshfield Clinic and other providers have sustained additional losses. In simple terms, for every dollar the Health Plan takes in it is spending $1.28.

We wish we could say with certainty why we are experiencing these losses, but we cannot. An evaluation team is under contract with HCFA to study the demonstrations in detail. Unfortunately, they have just begun their work and results may not be final for several years. We can today however, give you the benefit of our on-site experience and thoughts. First, there exists a strong possibility of adverse selection. By adverse selection, we mean the enrollment of a group of Medicare beneficiaries that have a greater need for medical services than the average Medicare beneficiary of the area, after adjusting for age, sex, welfare, and institutional status. You do not need any extensive study to come to this conclusion; you simply have to consider the setting and put yourself in the shoes of a Medicare beneficiary. To join you must pay $25.94 per month (less comprehensive alternative Medi-gap policies are presently priced around $20.00). You do not have to change doctors. There are no pre-existing illness clauses; if you join your total coverage for all your medical services commences with your effective date. Preventive services are covered in full. Under the circumstances the only barrier is the $25.94. This can easily be weighed against past or anticipated future medical expenditures. Clearly under these circumstances one would not assume an 'average' enrollment.

The greatest reason for the loss has to do with hospital utilization. Access to the hospital is controlled by the physician and the same physicians provide the care to area beneficiaries in or out of the demonstration program. The insurance status of patients is not identified to Marshfield Clinic physicians we strive to provide quality medicine without regard to financial status. Therefore, it is hard to visualize an explanation other than adverse selection.

A second contributing factor may be increased utilization due to the elimination of financial barriers. Beneficiaries may have been kept from seeking needed medical services on the basis of their fear of how they could pay for hospital and medical services. Many enrollees waited to obtain needed medical care until this barrier was lifted. Whatever the reason(s), a key additional issue relates to whether or not the higher utilization is permanent, or some type of start up phenomena. If beneficiaries are getting needed care in a more timely fashion, what will be the long-term impact?

In spite of the financial problems being incurred by the Medicare demonstration presently, the Health Plan sponsors are convinced that the services provided under it are necessary. Unfortunately, the losses have become so large that if left unchecked the situation could endanger the entire Greater Marshfield Community Health Plan, not just the Medicare demonstration.

Under the demonstration program reimbursement for Marshfield was based on an adjusted community rate development. The adjusted community rate attempts to tie the Medicare rate to the market place by developing use factors that can be used as multipliers on the components of the basic community rate. In our case, we had no experience with which to derive these multipliers for the current fiscal year. Our approach was to use information from other HMO's and from the Health Care Financing Administration. Ideally, actual experience should be used to construct the adjusted community rate. Presently, we are

being paid 98% of the Health Care Financing Administration's estimate of what their costs would have been, in the area, without the demonstration program. With the benefit of a full year of actual experience our projected rate for next year, based on an actuarial method of computation, is about 50% higher than our current rate. While we have not formally computed an adjusted community rate, the indications are that an adjusted community rate based on our actual experience will be as high or higher than the actuarial rate we proposed to HCFA for next year. We do not yet know what HCFA's estimate of their cost will be for our area for next year, although we were told that their average per capita payments in the counties we market the program in have gone up substantially. In spite of this, we are projecting a considerable difference between our projected revenue requirements and HCFA's estimate of their average adjusted per capita costs. We believe it is important to go forward with the demonstration. However, in this year alone it has depleted all of our Health Plan reserves, and puts the entire Plan in a loss position. We are not now in a position to make any reductions in our estimated revenue requirements for next fiscal year.

We believe the average adjusted per capita cost as calculated by HCFA does not reflect the experience of the group we enrolled. We understand that it is permissible under section 1876 to make additional adjustments when evidence of differential utilization within the AAPCC categories exists. We believe this flexibility is critical if HMO's are to contract on a risk basis with the Health Care Financing Administration, and the interests of both the Social Security Trust Fund and the HMO's are to be maintained.

With respect to the Competitive Health and Medical Plan (CHAMP) Act of 1981, we would like to make the following observations:

1) We support the general direction of the Act in that it would provide

access to competitive medical plans for the Medicare beneficiary and encourage risk as opposed to cost contracting. We believe there are advantages to all parties; the beneficiary, the Competitive Medical Plan, and the government.

2) We believe the current method HCFA uses to estimate its expenditures in an area on a prospective basis will not always serve the purpose of the CHAMP Act. We cite our experience as an example of how such a methodology could jeopardize the viability of a Competitive Medical Plan. We would stress that language be introduced to provide flexibility in those cases where the HMO's adjusted community rate (ACR) exceeds 95% of the AAPCC, particularly when the ACR is based on actual experience.

3) We believe both the AAPCC and the ACR need to be continually improved, as operational experience dictates. Use of the ACR should tie Medicare reimbursement to the non-Medicare marketplace, and has the advantage of being based on the actual Medicare population enrolled. If Competitive Medical Plans offer more efficient delivery of health services, they should not be penalized for enrolling those most in need of care; on the contrary, they should be encouraged to do so. If the AAPCC is below the ACR, then for the sake of the beneficiaries alone, some review and exception procedure should be available to resolve the discrepancy.

Mr. Chairman, in summary our experience under the Medicare demonstration program has clearly shown that many Medicare beneficiaries are interested in receiving this medical care under the auspices of a Competitive Medical Plan. However, a single, unflexible approach to premium rate determinations will not serve the mutual interests of all involved parties. We are most willing

to share our experience under the demonstration program in more detail. To that end we will avail ourselves to the Committee staff at your request.

Thank you.

STATEMENT OF

JOHN P. O'CONNELL

The Fallon Community Health Plan is a Federally qualified Health Maintenance Organization located in Worcester, Massachusetts. It is jointly sponsored by The Fallon Clinic and Blue Cross of Massachusetts. It was funded with the help of a $650,000 in Federal Initial Development Grant and a $500,000 grant to expand its geographic area of coverage. It was authorized to use 1.6 million dollars in Federal loan money. It has, however, only used $160,000 of this amount. The Plan became operational on Febuary 1, 1977 and Federally qualified on November 21, 1978.

Worcester is the second largest city in Massachusetts. It has about 175,000 residents and there are about the same number in the immediate environs that make up the Fallon Community Health Plan service area.

The Plan is a one group, "Group Model Health Maintenance Organization." All services to Plan members except for emergencies are either provided by or arranged by the physicians of the Fallon Clinic. The Fallon Clinic has existed in Worcester for over 50 years. It has 60 full time physicians practicing at three large modern Clinic sites. It must be considered to be in the mainstream of American medical practice. Whatever success the Fallon Community Health Plan has had is due in a

very large part to the reputation of the Clinic for high quality medical care.

The other co-sponsor of the Fallon Plan is Blue Cross of Massachusetts. It is a Hospital Service Corporation and Part "A" Medicare Intermediary. It is a companion in operations of Blue Shield of Massachusetts, a Medical Service Corporation and Part "B" Medicare Intermediary. Together Massachusetts Blue Cross and Massachusetts Blue Shield constitute the largest Hospital-Surgical-Medical carrier in the Commonwealth.

In four and one half years of operation, the Plan has grown to cover 34,000 persons including both subscribers and dependents. In 1980 it reached a break even point in operations. Its membership includes 27,600 employer group numbers, 800 Medicaid members and over 5,600 Senior Plan members enrolled under our experimental program.

At a time when our total membership was only 5,000, we responded to a HCFA request for proposal. At the time we had no existing program for persons over 65 years of age. We proposed to make available to Medicare beneficiaries, in our service area, a comprehensive set of benefits in lieu of traditional Medicare coverage. These benefits were to include all covered Part A and B services, all deductible and co-insurance items, preventive

services, such as physical examinations without sign or symptom of illness, nutrition service, social service, refractions, eyeglasses and prescription drugs subject to a $1.00 co-payment charge. Our monthly dues for services were determined in accordance with a protocol agreed to by HCFA. Basically it was a cost based adjusted community rate. HCFA was to pay no more than 95% of the adjusted area costs and the member was to pay the balance. In year one and year two of the experiment, the member portion has been $7.50. The HCFA portion has been approximately $120.00.

We enrolled 3.600 Medicare members in year one of the program and in year two that number increased to 5,600 approximately 10% of Medicare beneficiaries in the area.

In entering into this program, we hoped to demonstrate certain things. First: that a Plan such as the Fallon Community Health Plan, "Senior Plan," will lead to increased receptiveness by qualified Health Maintenance Organizations to enroll Medicare (Title XVIII) beneficiaries.

We think the experiment has been good for us. It supplied members and a secure cash flow at a crucial time in our development. Finances are very tight, but nevertheless successful. We hope to continue this program, authorized

by legislation. This is not only for the benefit of the Plan but for its "Senior Plan" members who have come to rely on it for health care services. We believe that other programs would want to emulate our actions and our success.

Second: we hope to demonstrate that a Plan such as the Fallon Community Health Plan, "Senior Plan," is cost effective. We think we have done this. The government is saving 5% on the cost of covered part A and B services. The value of benefits in addition to covered part A and B services provided each member including deductible and co-insurance items, preventive services, refractions and prescription drugs is $39.23 per month. The member pays only $7.50 for these benefits.

We have experienced some different utilization patterns than were originally anticipated. For example, we projected 2,300 days of hospitalization per thousand members enrolled and have experienced 2,700. This corresponds to over 4,000 hospital days per thousand population of persons over 65 years of age in the state. Out-patient visits, however, were slightly lower than we anticipated. We believe that adjustments within the protocol could accommodate these differences in future years, as we enter experience into the capitation calculation. of the original 3,500 members that enrolled in the first open

enrollment period all but 206 have received services at the clinic. We feel that the somewhat high rate of hospitalization is due, in part, to previously undiagnosed pathology discovered on the initial clinic visits. The clinic is now contacting the remaining 206 enrolled persons to arrange physical examinations. When this is complete, it is felt a certain backlog of unmet need will have been met.

Third: what we hoped to demonstrate was that a Plan such as the Fallon Community Health Plan, "Senior Plan," can attract Medicare beneficiaries to enroll in a prepaid system. We have, infact, enrolled 10% of the Medicare population of our area within a one year period. The marketing was by an unlimited open enrollment without underwriting and without exclusions for preexisting conditions. We advertized in the newspapers, conducted open meetings at the Clinic and asked each Blus Cross medex subscriber to fill a dual choice election card.

The fourth and final thing we hoped to demonstrate was that a Plan such as the Fallon Community Health Plan, "Senior Plan", can be offered successfully in a Health Maintenance Organization of moderate size. We think that we have done that.

In conclusion, we endorse the proposed legislation.

It will save the Federal Government money and improve the living standard of our senior citizens.

I must say that I have some reservations regarding some of the provisions of the bill. I do not endorse the so called rate book approach to rating. I believe that each years capitation should be based on the characteristics of the population covered the previous year. To do otherwise would make budgeting complex and income unpredictable.

I do not believe that there should be high and low coverage options or programs for persons with part B coverage only. We have only one program at one rate of dues for our under 65 population and one administrative structure to administer it. Explaining differences in coverage to persons over 65 is extremely difficult. Imagine explaining to a Senior Citizen who is not familiar with health care coverages that there are in fact four options, a high option and a low option for persons with part A and part B and a high option and a low option for people with part B only.

I do not think that there should be institutional or health status adjustments to the capitation. The information regarding these items is not in the Medicare files. I know of no reasonable satisfactory or reliable way of accumulating

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it. Also, there is a danger that HMOs would be penalized in subsequent years for keeping their members out of institutions.

The beneficiary's medicare health insurance card should show that he or she is a Health Maintenance Organization member. The words "Part A Hospital Insurance" and Part B Medical Insurance" should not appear.

Finally there is one area where we have experienced some severe problems. That is assuming liability for persons who are hospitalized on the day that their coverage in the Health Maintenance Organization becomed effective. It is traditional for health insurance carriers and Health Maintenance Organization to assume liability for an episode of hospitalization if the member is covered on the day of admission and to cover the patient until discharge, even though the patient may transfer his coverage to another carrier in the interim. We have covered a patient who was hospitalized four months prior to the date that his coverage became effective and he still remains hospitalized now, seven months later. We are paying his bills, however, we feel that this is an unreasonable area of exposure. We should not be responsible for the institutional bills for admissions prior to the date that coverage becomes effective. On the other hand we should be responsible for admissions that occur while

coverage is in effect but continue after coverage terminates.

We feel that by this experiment we have shown that the program works. We have provided needed services to a large number of elderly persons. We have saved money for the government and our members. We think that by meeting a backlog of unmet needs we have improved their health status.

I hope that you will propose and pass the bill here under consideration. If you do, you will be taking a giant step toward meeting the needs of our aging population and toward cost containment in the delivery of health care.

Thank you for your kind attention.

STATEMENT OF

MERWYN R. GREENLICK

DIRECTOR

HEALTH SERVICES RESEARCH CENTER

OF

KAISER FOUNDATION HEALTH PLAN, INC.

BEFORE THE

SENATE FINANCE SUBCOMMITTEE ON HEALTH

UNITED STATES SENATE

ON

HMO INVOLVEMENT IN MEDICARE

July 30, 1981
Washington, D.C.

Statement of Kaiser Foundation Health Plan, Inc.
Before the
Senate Finance Subcommittee on Health
United States Senate
July 30, 1981

Mr. Chairman, and Members of the Subcommittee: I am Merwyn R. Greenlick, Director of the Health Services Research Center of Kaiser Foundation Health Plan, Inc., of Portland Oregon. I am also Director of the Medicare HMO demonstration in Portland, sponsored by the Health Care Financing Administration and Kasier Permanente Medical Care Program.

Kaiser Foundation Health Plan, Kaiser Foundation Hospitals, and eight independent Permanente Medical Groups comprise the Kaiser-Permanente Medical Care Program. The Program is an economically self-sustaining, organized health care delivery system that provides health services on a prepaid, direct-service basis to over 3.9 million members in California, Colorado, the District of Columbia, Hawaii, Maryland, Ohio, Oregon, Texas, Virginia, and Washington. Kaiser-Permanente members receive services through 28 hospitals, 85 out-patient facilities, more than 4,200 full-time physicians and over 36,000 other employees.

The Kaiser-Permanente Program is the largest prepaid group practice program in the United States. The Program's membership includes more than 200,000 individuals who are Medicare beneficiaries. The vast majority of these individuals belonged to Kaiser Foundation Health Plan before they reached 65 and continued their membership by enrolling in the Program's Medicare supplemental plan.

The purpose of this statement is to discuss changes in the Medicare program that would create greater incentives for Medicare beneficiaries to seek HMO membership and to encourage HMOs to enroll more elderly citizens. Our views are based not simply on the importance we attach to incentives as a key to development of a more efficient health care delivery system, but on the experience of a Medicare demonstration project that Kaiser-Permanente is currently operating in Portland, Oregon. The project is one of five sponsored by the Health Care Financing Administration (HCFA) involving HMOs and the Medicare population.

There have been a number of prior efforts to change the way Medicare pays HMOs, but it is especially important that a satisfactory method of payment be adopted at this time. During the past eight years, federal policy toward HMOs has been mixed. Financial support has been provided under the HMO Act and pursuant to Section 1310 of the Act, millions of employees, mostly under the age of 65 have been offered membership in an HMO for the first time. On the other hand, the existing methods by which Medicare pays HMOs are inadequate. They do not provide incentives for HMOs to enroll members or for Medicare beneficiaries to join HMOs. As a result, the number of Medicare beneficiaries enrolled in HMOs is small, and most Medicare enrollees belonged to the HMO before they became eligible for Medicare.

The federal government will be terminating its financial support of HMOs. As it does so, we believe the adoption of a

satisfactory Medicare HMO payment provision is imperative so that HMOs will finally be able to obtain access to the largest health benefits program in the country.

Of more importance, is the fact that millions of Medicare beneficiaries have been effectively denied the opportunity to be members of HMOs. Such membership can be a meaningful benefit. HMOs are organized health care delivery systems that provide coordinated care. Their physicians are able to guide the elderly through the often confusing maze of specialists and services necessary for their care. HMO benefit plans are generally comprehensive with no deductibles and only nominal copayments so that total health care costs are predictable and financial catastrophe because of acute health care costs is virtually impossible. In addition, the large amount of paperwork that burdens most Medicare beneficiaries does not exist in HMOs.

Finally, the cost of an HMO for comparable benefits is generally less than the cost of fee-for-service care. This is largely attributable to appropriate hospital use. In the Portland demonstration, if hospitalization continues at current levels, it will represent less than 60% of the use rate of Medicare persons in community hospitals in Portland.

Despite these factors, only a small number of Medicare beneficiaries are members of HMOs. When Medicare was enacted in 1965, it did not contain any provision to pay group practice prepayment plans (one of the HMO prototyes) on a basis consistent

with the way they were paid for the non-Medicare members. Instead, hospitals which served group practice prepayment plan members were paid under Part A on the same basis as other hospitals and such plans were paid for Part B services on a per capita basis which was cost based. The only other option was to submit bills and be paid on a fee-for-service basis.

In 1972, Congress added Section 1876 to Title 18 of the Social Security Act. This section provided for an improved method of payment for HMOs. It provided for a capitation payment for both Part A and B services on either a cost or risk basis and established the important principle that an HMO that chooses a risk contract would receive a portion of the savings (the difference between the average cost in the area for fee-for-service Medicare beneficiaries with smiliar characteristics to the HMO's members and the HMO's costs for its Medicare members).

This provision contained a number of problems. First, the final payment to the HMO is made retrospectively and may not be determined and paid to the HMO until two or three years after services are provided. This requires an HMO to finance the use of the savings if it uses them to reduce the costs of, or add benefits for Medicare members, a risky and expensive provision. Second, Section 226(b) of P.L. 92-603 (the legislation which added Section 1876 to Title 18) provides that when an HMO enters into a risk agreement all its existing members must agree to obtain <u>all</u> their Medicare covered services through the HMO or terminate their membership. Under its general provisions, Medicare pays

for services received outside the HMO. Making this change in coverage would be traumatic for many older persons. This is the major reason our Program and other HMOs with large Medicare memberships have not entered into Section 1876 risk contracts. We believe that requiring long-standing Medicare members of an HMO to limit their sources of services, or no longer belong to the HMO is unreasonable. Third, Section 1876 requires an HMO to offer one benefit package that covers only Medicare services. This excludes preventive and health maintenance services. This requirement is alien to the concept of health maintenance organizations and makes no sense. Finally, there is no requirement in Section 1876 about how HMO savings are to be used. Thus, HMOs need not pass on the savings to their members in the form of added benefits or reduced premiums.

The present Medicare payment proposal resolves those problems. Payments would be determined prospectively with no retrospective adjustments. An HMO would know in advance how much it would receive, could plan accordingly and would not have to finance the "savings." Existing Medicare members of an HMO would have the option of changing to the new program or remaining under the old one. It is important to note that in our Portland demonstration, when this option was offered to 9,000 existing Medicare members, only 3,000 of them applied for the new program. HMOs would be required to pass their savings on to their members. This is an important requirement

to assure that Medicare beneficiaries receive full benefits and to provide maximum incentives for them to join the HMO. Finally, an HMO would be able to develop benefit plans which covered preventive and health maintenance services and would not be required to offer a Medicare only benefit plan.

The proposal contains two new concepts: prospective average per capita costs and the adjusted community rate. These are necessary in order to determine the amount Medicare pays an HMO for each person enrolled and the amount that must be passed on to the Medicare members. When it was first introduced, there was considerable concern, especially among some Senate staff, about whether it was possible to develop prospective per capita costs and adjusted community rates. In addition, there was a serious question about whether Medicare beneficiaries would join an HMO.

In order to determine the answers to these questions, HCFA requested applications for demonstration projects and we submitted a proposal. The project has shown that it is possible to develop prospective average per capita costs. There are more than 300 rating catagories in the rate book we use. They reflect differences in age, sex, disability status, institutional status,welfare status and geographical area.

The project, which we call Medicare Plus, has shown that the methodology for developing an adjusted community rate

is available and workable. It is based on the existing Medicare method of paying HMOs on a cost basis with appropriate adjustments for utilization differences and time and complexity factors.

Finally, our demonstration project and the ones in Marshfield and Worcester have shown that Medicare beneficiaries will join HMOs. On May 23, 1980, Kaiser Foundation Health Plan of Oregon accepted the first application for enrollment under the HCFA demonstration with a plan to enroll 4,000 new Medicare members within the first six months. The membership goal of 4,000 was reached by October, 1980, so a decision was made in November to increase the total to 5,500 new Medicare beneficiaries. This new goal was achieved on January 1, 1981.

It is important to note that this new membership had about the same age and sex composition as the total Medicare population in the Portland area. We made a substantial effort to enroll a representative group of the Medicare beneficiaries in the community. These efforts included the unprecedented step for us of using media advertising to assure wide knowledge of the project among Medicare beneficiaries.

I will describe briefly how the proposal works in Portland. In the Portland metropolitan area it costs Medicare $119.13 a month, on average, for the medical care of Medicare beneficiaries with characteristics comparable to our new members who receive services in the traditional medical care delivery system. This

monthly amount is the adjusted average per capita cost (AAPCC).

Under the demonstration, Kaiser Foundation Health Plan of Oregon (Health Plan) receives 95 percent of the AAPCC, or $113.65. Thus, the federal government saves five percent at the outset. The beneficiary also is rewarded, an incentive that we believe is absolutely critical to attracting more elderly citizens to HMOs by receiving benefits beyond the Medicare A and B package. These benefits include the standard preventive services offered by our Health Plan and result from the requirement that the Health Plan pass along to its Medicare Plus members the difference between the AAPCC and its adjusted community rate.

The adjusted community rate (ACR) is the rate for providing the Medicare A and B benefit package to our Medicare Plus members. It is $94.60. Thus, the difference between 95 percent of the AAPCC ($113.65) and the ACR is $19.05. These "savings" pay for the benefits of Medicare Plus including the coverage of all medicine, deductibles, and coninsurance and the benefits not covered by Medicare, such as routine physical examinations, examinations for hearing, vision care and most immunizations.

The savings also pay for a new service tailored specifically for Medicare Plus enrollees to facilitate their use of our health care delivery system. A new Medicare Plus Member Handbook was developed and written materials were mailed

to new enrollees to obtain current health status information from them. This form was reviewed by a Permanente physician who determined which members needed to be contacted and scheduled immediately for a doctor's appointment.

In addition to the comprehensive supplemental coverage for which Medicare members pay nothing, half of the persons who applied for Medicare Plus were offered a choice of benefit options for which additional rates are charged. This choice was part of the experiment to test which benefit packages offered the greatest incentives to enroll in a health maintenance organization. These additional benefits are priced as follows. For $6 a month, our Medicare Plus members in Portland can receive prescription drugs, eyeglasses and hearing aids, plus the standard A and B package, prescription drugs, eyeglasses, hearing aids, and comprehensive dental care.

We believe there are a number of other provisions that should be included in any Medicare HMO payment proposal. First, HMOs should be required to enroll members without medical review. The only limitation on enrollment should be the capacity of the organization. This is the way we are enrolling in Portland. It eliminates favorable selection by the HMO. Second, HMOs should be able to have their hospital bills processed by Medicare at their option as provided under existing law. This will assure that HMOs are not discriminated against in terms of hospital payments. Third, the cost option for HMOs should be retained.

New HMOs and those with small Medicare enrollments may be unable or unwilling to assume the risk involved. Fourth, HMOs should be allowed to restrict enrollment to persons covered under both Parts A and B. This is what we are doing in Portland and it eliminates many administrative problems and confusion, especially at the beginning of a new program. Finally, an ongoing enrollment system should be established. At a minimum, as persons become eligible for Medicare, they should be advised of their right to enroll in any HMOs that are in the area and they should be informed of the benefits offered by such HMOs.

The Portland demonstration has validated the purposes of S 1509, the bill introduced by Senator John Heinz that would reform the way Medicare reimburses health maintenance organizations (HMOs). The demonstrations prove that if Medicare beneficiaries are rewarded for their willingness to enroll in organized, efficient health care delivery systems by sharing the savings with the Medicare program, they will enroll. The consequences of more Medicare participation in HMOs are long-term cost savings for Medicare, more benefits for the elderly and creation of a more competitive heatlh care delivery system. Competition is stimulated by offering Medicare beneficiaries a choice-- the same choice that Congress now requires private employers to offer their employees.

We believe our demonstration program in Portland has shown that a rational system including prospective payment can be

designed and implemented which will result in lower total costs for the Medicare Program and Medicare beneficiaries than could be achieved in the fee-for-service sector for comparable Medicare benefits.

We wish to commend Senator Heinz and the cosponsors of S 1509 for their understanding of the uniqueness of HMOs and for authoring a payment proposal that recognizes that uniqueness. We believe the bill is well balanced and will benefit HMOs, their Medicare members and the Medicare program. However, the bill has a larger importance than the significant improvement in the Medicare program it will make and the benefits it will provide Medicare beneficiaries. S 1509 is an important step in the efforts of the federal government to recognize cost effective health care delivery systems. It will assist in their growth and development, make them more available to all Americans and is likely to have a beneficial impact on the cost of health care in the United States. Now is a particularly appropriate time for the Congress to act, as it moves to recast federal HMO policy and encourage the development of competition in the health care industry.

Senator DURENBERGER. Our next witness is William D. Ryan, who is chairman of the board of directors of the Rochester Area Hospitals Corp., and Donna I. Regenstreif, executive vice president, Rochester Area Hospitals Corp.

A PANEL OF WILLIAM D. RYAN, CHAIRMAN OF THE BOARD OF DIRECTORS, ROCHESTER AREA HOSPITALS CORP., AND DONNA I. REGENSTREIF, EXECUTIVE VICE PRESIDENT, ROCHESTER AREA HOSPITALS CORP., ROCHESTER, N.Y.

Mr. RYAN. As I testify before you, I bring good news from Rochester, N.Y. We in Rochester are showing that old-fashioned American ingenuity and determination to work together is enabling our hospitals to achieve the lowest rate of cost increase in the Nation.

We accomplished that while improving our solvency and maintaining our substantial commitment to the high standards of quality, access, and educational programs in those hospitals.

Many have asked whether it is realistic to hope that the Federal Government's plan to scrap burdensome regulation, promote competition, in partnership with the best of free enterprise, can actually curb cost escalation in the inflation-prone hospital industry.

The hospitals in Rochester, N.Y., are demonstrating that the answer to this question is a definite "yes." They are showing that a new prescription to control hospital costs works.

In 1980, the first year of the new program, our hospital costs increased at about half the national rate and well below the inflation rate reflected in the CPI. Had the rest of the hospitals in the country performed as well, we could have saved upward of $7 billion.

Faced with an alarming deterioration in our hospitals' financial condition, we knew we needed a radical new approach. We worked out a contract that we now called "HEP," the hospital experimental payment program. We formalized our organization as a new, private, not-for-profit corporation, named RAHC, the Rochester Area Hospitals Corp.

Far-sighted leaders of our physician, university, government, and business community, combined with the willingness of New York's health and social services departments and the Federal Health Care Financing Administration to share our conviction that a local system of self-control and competition was better than externally imposed regulation, enabled us to come together to implement a 5-year HEP contract on January 1, 1980.

Other communities which have different histories and face different situations, might well come up with even better solutions than ours; nevertheless, we think there is much to learn from the model that is working, and working well, in Rochester.

I would like to now introduce the executive vice president of RAHC, Dr. Donna I. Regenstreif, to give you some further information.

Senator DURENBERGER. Welcome.

Dr. REGENSTREIF. Thank you very much, Mr. Chairman.

In the late 1970's, as you have heard, we had in Rochester an excellent and economic hospital system that was in financial trouble because of stringent New York State hospital cost control programs.

We knew that we needed to correct faults in design of the hospital payment system as a first step in solving some of these problems.

We decided to begin at ground zero and to think about what financial incentives needed to exist to insure that voluntary hospital boards, their managements, and their physicians would be rewarded for pursuing policies which enhance cost effectiveness and quality both for the individual hospital and for the community's health care system as a whole.

Traditional reimbursement systems reward volume increases by paying on the basis of service rendered. If efficiency or productivity improves, revenue declines, often resulting in a more bleak financial picture for a successful hospital than would have been the case with less effective management.

Under our program, cost savings realized by a hospital are retained by it, because hospital revenues are not linked to incurred costs.

Further, all certificate of need projects for new services, as well as for volume adjustments, must be paid for out of a centralized and limited contingency fund which puts all hospitals collectively at risk for planning decisions and their associated costs.

In return for waivers of traditional reimbursement principles, our nine hospitals committed themselves to maintain quality of care and to share savings with the contracting payers, medicare, medicaid, and Blue Cross, within the specified level of reimbursement.

Our activities are paid for by dues from each hospital and we receive private philanthropic support through a grant from the John A. Hartford Foundation of New York City.

As soon as we became accustomed to operating under the HEP system, it became apparent to us that there were further problems in hospital planning and management that needed to be addressed.

We found that physicians' decisions regarding patients' medical needs were the main factors that drove the requirements for hospital services.

Yet, there was no way these orders could be translated into decisions at the overall hospital level. The lack of integration of clinical management into the overall management of the hospital and from there into community-wide planning and financing decisions is a major need which we must remedy.

Another problem relates to the lack of integration of different aspects of the health care system; for example, the hospital and long-term care systems of the broader health system.

In summary, in Rochester, N.Y., all of our hospitals in an entire metropolitan area, over two counties, have entered a single corporation and an experimental financing system, with powerful incentives for cost control, constructive competition, and enhancement of individual hospital autonomy.

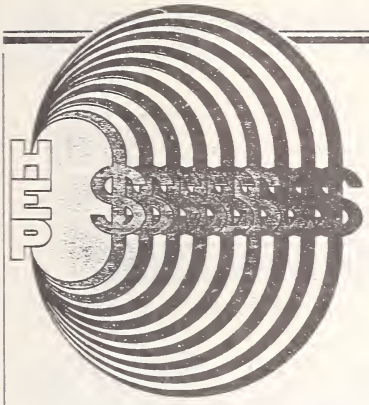
These hospitals reported the lowest rate of cost increase in the Nation in 1980 by taking positive steps at the local level to address issues fundamental to the continuation of a voluntary health care system in America.

Mr. Chairman, we have our 1980 annual report and the manuscript scheduled to appear as the lead story in the September 1981

issue of Hospital Financial Management Journal. This explains our program in greater detail, and with your permission we would be pleased to submit it for the record.

Senator DURENBERGER. We will make it a part of the files of the hearing.

[The material follows:]



Experimental payments program

It's working

by James A. Block, M.D., Donna I. Regenstreif, Ph.D. and Leonard J. Shute

Editor's note: In 1967, Congress authorized the Medicare program to conduct healthcare experimental payment projects that would provide incentives for economy while maintaining or improving quality of health services.[a] It reconfirmed, in 1972, the Medicare program's authority to enter into incentive contracts with healthcare providers in which payment would be based on negotiated rates.[b]

The Health Care Financing Administration (HCFA) has a large number of waiver and demonstration programs, one of the most important being the Rochester Area Hospitals' Experimental Payments Program. It is a voluntary experiment not designed by or for a state rate-setting agency. It has resulted in significant improvements for its area's hospitals' financial conditions. *HFM* readers will be especially interested because components of this program may be usable in other parts of the country.

THE SOLVENCY OF ROCHESTER, New York, hospitals was seriously threatened as a result of rigorous New York State hospital cost containment policies that limited payments to hospitals from Blue Cross and Medicaid initially, and eventually brought hospital charges under state control.

This was happening despite a background of economic factors contributing to economy in healthcare costs in the area.

Prior to the Hospitals Experimental Payments (HEP) program, payment mechanisms for these hospitals were under government regulations that were sometimes contradictory, did not permit accurate hospital income prediction and invariably resulted in hospital administrations losing revenue when cost reductions were achieved.

Under these circumstances hospital administrators found it difficult to establish policies that could enhance patient care *and* maintain financial solvency.

Moreover, their ability to budget and plan effectively was adversely affected by frequent changes in reimbursement rules and regulations. By 1978, the solvency of the hospital system in Rochester and elsewhere in the state was seriously threatened, and some hospital administrators had resorted to liquidating portions of their endowment funds to underwrite routine activities.

A local system of self-control

Rochester hospital trustees were determined to develop a positive alternative to these difficulties. They would, on a voluntary basis, demonstrate their commitment to a local system of *self-control.* This system required a predictable fiscal environment to succeed.

It was against this background of difficulties that the Rochester Area Hospitals' Corporation (RAHC) was incorporated as a not-for-profit organization in July 1978,[c] after years of planning among the area's hospitals, their boards and medical staffs.

The HEP program was combined with information systems to enable community wide planning in response to community needs and ongoing efforts to assure quality and evaluate cost effectiveness of hospital services.

RAHC's initial task was to develop a payment alternative to test the assumption that a community, through voluntary local control and accountability, could simultaneously enhance its hospital system's excellence and control its rate of cost increase.

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a. See Social Security Amendments of 1967, PL 90-97, Section 402 (a).

b. Social Security Amendments PL 92-603, Section 222 (b).

c. Area-wide hospital planning dates back over four decades; early efforts are described in *The Rochester Regional Hospital Council.* L.S. Rosenfeld and H.B. Makover. Cambridge: Harvard University Press, 1956.

for Rochester-area hospitals

Thus, RAHC's mission is:

- To maintain and enhance the community's hospital system;
- Control the rate of cost increase of hospital services, ensuring the availability of needed hospital services in an era of increasing constraint on resources;
- Facilitate local decision making through enhanced communication and coordination;
- Maximize the cost effectiveness and benefit to the community of hospital services provided and planned.

The Hospitals Experimental Payments (HEP) program was developed to help achieve these goals. Its development was supported by dues from RAHC hospitals and a grant from The John A. Hartford Foundation of New York City. A contract was developed specifying the terms for a new hospital payment methodology consisting of a proposed prospectively determined community-wide cap on revenue for a three-year period to begin Jan. 1, 1980. It was signed by those representing all acute care hospitals in the area and by the Rochester Hospital Service Corporation (Blue Cross). The contract was forwarded to the State of New York, where it received approval from the Office of Health Systems Management and the Department of Social Services (Medicaid).

The U.S. Health Care Financing Administration (HCFA) approved the project in December 1979, and granted a waiver of Medicare and Medicaid reimbursement principles. HEP was implemented on Jan. 1, 1980; its term extended for an additional two years (through Dec. 31, 1984) with the agreement of all contracting parties at the end of 1980.

Nine hospitals are participating in the RAHC experiment; they range from two hospitals of under 100 beds in semi-rural communities to a tertiary care university medical center with more than 700 beds. In 1980, on entering the payment experiment, their aggregate expenses exceeded $270 million. They employed nearly 10,000 people and annually trained more than 600 residents in a variety of medical education programs. They serve a population of one million[d] and constitute the Northern Sub-Area of the Finger Lakes Health Systems Agency planning region.

The provision of needed high quality services presumes an understanding of the hospitals' major products and the association between patterns of resource use (or medical practice) and treatment costs. HEP offers predictable levels of revenue in support of the hospitals' activities. Concurrently, it creates a need for a clear statement of expected patient resource usage in order for a hospital to effectively plan, budget and monitor its performance. Thus, one important facet of RAHC activities has been the integration of all hospitals' financial, billing and discharge abstract information into a routine management reporting system. Individual hospital administrations use these reports in planning, management and quality assurance functions. On a community-wide basis, these reports assist in overall hospital system planning. HEP's payment approach thus offers hospital administrators totally different financial incentives plus a unique management and planning opportunity.

General features of HEP

HEP's general features are to promote the effective and efficient delivery of hospital services in the Rochester area and to maintain the solvency of the participating hospital administrations. HEP is predicated on the idea that a major cause of inflation in hospital costs is the faulty design of health payment systems. The incentives inherent in traditional payment systems, and New York's early efforts at state-wide regulation, do not promote

Continued on page 12

d. The two-county population is 750,000 and the nine-county regional referral area has a population of 1.2 million.

HEP: It's working

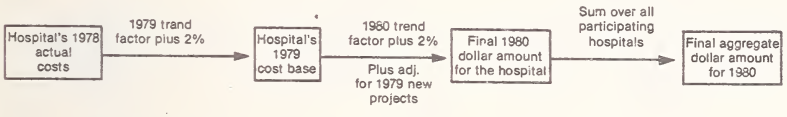
From page 11

these purposes. HEP encourages hospital cost containment through the introduction of appropriate incentives in the hospital financing system that affect both inpatient and outpatient services.[e]

These new incentives are, for the most part, the results of two features of the HEP system. They are:

1) Payments of each hospital are based, after the first year of the program, on that hospital's preceding year's payments without regard to its incurred costs. Cost savings realized by the hospital thus accrue to its benefit throughout the program.
2) Total revenue available to the community's hospitals is determined in advance of each year of the program. The available revenue covers all of the hospitals' expenses, including incremental operating expenses associated with approved Certificate of Need (CON) projects, increases in volumes of services, and costs associated with unforeseen events. This feature gives the hospitals incentives to work together to avoid unnecessary duplication of service, while preserving the autonomy of each hospital.

Exhibit 1: Computation of 1980 final dollar amount


Hospital's 1978 actual costs
1979 trend factor plus 2%
Hospital's 1979 cost base
1980 trend factor plus 2%
Plus adj. for 1979 new projects
Final 1980 dollar amount for the hospital
Sum over all participating hospitals
Final aggregate dollar amount for 1980

Causes of hospital cost inflation

HEP addresses two principal causes of hospital cost inflation. They include:

1) *The volume problem*—The incentives of traditional reimbursement to reward high rates of admission, long lengths of stay and increasing resource use per admission;
2) *The planning problem*—Planning agencies' approval of projects under CON regulation neither reflects an accurate assessment of financial reasonableness nor links projected expenses with actual experience.

HEP's response to each of these issues is more diverse and clearly delineated than in any other hospital payment system in the United States today. These responses are:

1) *Volume:* Under HEP, hospital financial departments are compensated for increases in admissions according to a formula designed to discourage marginal admissions and to promote increased use of outpatient services. All payment for additional services is drawn from a contingency fund; thus hospital administrations are collectively at risk for unwarranted increases in volumes of service. Further, there is a 2 percent corridor before increased admissions are paid and a conservative marginal cost factor (40 percent) applied to payments for increased inpatient admissions. Further, hospitals receive no compensation for increased resource use per patient.
2) *Planning:* The operating costs of CON-approved projects are drawn from a community-wide contingency fund and are subject to negotiation between RAHC and the hospitals' financial staffs. Thus, the hospitals are collectively at risk for planning decisions and their associated costs; and there is expertise and incentive to improve cost effectiveness.[f]

HEP is a prospective payment system that uses the hospitals' 1978 allowable costs (defined in accordance with Medicare principles) as the basis for establishing payment levels for the five-year term of the experiment. Two calculations are fundamental to the system: 1) an overall limit on the annual net patient revenue for *all* hospitals called the "final dollar amount," and a limit on 2) an *individual* hospital's annual net patient revenue, which is the hospital's "final allowable cost base."

The final dollar amount, sometimes referred to as the "total revenue cap," was calculated for 1980 by projecting each hospital's 1978 base-year costs (adjusted for the incremental operating costs of CON-approved projects implemented between the base year and 1980) to the rate year, using in-

e. RAHC's chief reimbursement consultant in development of HEP was John S. Cook, D. Phil., former chief rate analyst with the Maryland Health Services Cost Review Commission. Certain features of the Maryland system and of the MAXICAP project are to be found in the HEP program. MAXICAP was a concurrent effort to develop a regional planning and reimbursement methodology which was developed with the cooperation of HCFA, National and Rochester Blue Cross, the New York State Hospital Association, and the Finger Lakes Health Systems Agency, but was never implemented. See Sorenson, A.A., Ph.D. and Saward, E.W., M.D.; "An Alternative Approach to Hospital Cost Control: the Rochester Project;" *Public Health Reports*. 93:311-317, (1978).

f. During recent negotiations in connection with CON incremental operating expenses for increased capacity for open heart surgery, the final negotiated level of incremental expense approved by the RAHC board was some $450,000 lower than had been originally proposed by the sponsoring hospitals.

flation or "trend" factors to account for price increases in the goods and services that hospital managers use and a 1 percent annual provision for working capital. In 1981 and subsequent years, the final dollar amount is based on the preceding year's final allowable cost bases (which are explained below), exclusive of adjustments for volume, plus an amount for inflation.

Final dollar amount

In addition, 2 percent is added each year to the trend factors to allow payment for increased volumes of hospital services, incremental operating expenses associated with CON projects, unforeseen events and various other special projects consistent with the incentives of HEP. This 2 percent of a hospital's final dollar amount is paid into a "contingency fund" which is held and disbursed by RAHC. Any balance remaining in the fund at the conclusion of the experiment is shared equally by the hospitals and the payors and distributed among them in proportion to their contributions to the fund.

The sum of all the final dollar amounts of the individual hospitals is called the "final aggregate dollar amount." This is the maximum amount of net patient revenue that all the participant hospitals may share in a given year and is diagrammed in Exhibit 1.

Final allowable cost base

While the final dollar amount limits the amount the hospital system as a whole may receive, the final allowable cost base defines the revenue an individual hospital can receive for services to patients, since it is the base on which the liabilities of the contracting payors are established. It is also a cap on revenue because a hospital's total net patient revenue from all sources in excess of the final allowable cost base must be paid into the contingency fund. Any excess revenue thus accrues to the system as a whole and not to an individual hospital. This aspect of the final allowable cost base extends the revenue cap to *all* classes of payors not only the three contracting payors.

Calculation of the final allowable cost base, as of the final dollar amount, uses 1978 base year costs with adjustments for CON projects and is diagrammed in Exhibit 2. In 1979 and 1980 only, the hospital managers were provided a 1 percent increase over the trend factors for working capital. Hospitals' final allowable cost bases are also increased by payment for increases in service volumes according to contract formula.

A policy common to all prospective payment systems and used by all hospital rate-setting agencies is not to put hospital administrations at risk for cost increases beyond their control, for example, those associated with general economic inflation. The combinations of goods and services consumed by hospitals is different from that of other sectors of the economy. The effect of inflation on hospitals is not accurately reflected in the indexes developed by the Bureau of Labor Statistics (BLS) or other economic forecasters. In order to implement HEP, a system was developed called the "trend factor methodology" to measure more precisely the effect of inflation on hospital costs.

Exhibit 2: Computation of a hospital's 1980 final allowable cost base

Hospital's 1978 actual costs
1979 trend factor plus 1%
Plus adj. for 1979 new projects
Hospital's 1979 projected costs
1980 trend factor plus 1%
Plus adj. for 1980 new projects
Hospital's 1980 allowable cost base unadjusted for volume
Volume adj. 1980/78
Hospital's 1980 final allowable cost base

This methodology separates each HEP hospital's 1978 costs into 50 components. These include wages, benefit categories (FICA, medical insurance), food, medical supplies (blood products, drugs, X-ray film), depreciation on movable equipment, building and fixed equipment.

Each of these cost components is assigned a weight which is its percentage of total costs. A proxy is assigned to each of these weights which estimates the price movement in that cost component for a stated time period. Some of these proxies are involved in the computation of the Consumer Price Index (CPI) and other indexes published by BLS.

For example, the subcomponent of the CPI which measures increases in food prices is the proxy used for the food cost component. Proxies are specified in the HEP contract and are calculated or estimated by RAHC at given intervals each year.

The overall trend factor for each hospital is the sum of the products of the proxy multiplied by the weight for each cost component.

The HEP trend factor differs from the methodology in the prior payment formula in three ways. They include:

1) The HEP trend factor is hospital-specific. The weights used in the computations are those of an individual hospital as opposed to an average of many hospitals;
2) The proxy for depreciation on buildings and fixtures is the actual movement in this cost category from one year to the next. If a hos-

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pital's depreciation on building and fixed equipment increased 10 percent in 1980 over 1979, then the proxy used is 10 percent;

3) The proxy for wages and salaries (about 50 to 60 percent of a hospital's total costs) is related to the weighted average of actual salary increases given to production workers and working supervisors in the Rochester area. This ties the hospital's allowance for salary increases to the experience of the local labor market.

Apportionment of the allowable cost base

The allowable cost base defines the liabilities of the contracting payors. Distribution of the allowable cost base among the contracting payors is accomplished using standard Medicare apportionment techniques. Patient days by payor class is used to distribute routine costs. The ratio of charges-to-charges-applied-to-costs (RCCAC) is used to apportion ancillary and outpatient costs among contracting payors.

Under traditional New York State reimbursement, Blue Cross and Medicaid pay hospitals according to the average cost per day for all patients. This has led to shortfalls in revenue and cross-subsidization among payors. By applying the same system to all payors, this cross-subsidization should be eliminated under HEP. Payments to hospitals are made on a concurrent basis similar to Periodic Interim Payments (PIP) under Medicare. Interim payor liabilities are established using the latest audited apportionment statistics to calculate weekly payments.

It should be pointed out that the first year's influence on the change to the RCCAC methodology, the concurrent payments and the provision of the contingency fund had the effect of increasing Blue Cross' liabilities to the hospitals 6 to 7 percent over the trend factor. However, future increases in Blue Cross payments should be limited to approximately the trend factor.

The contingency fund

The hospitals' weekly payments include an amount for the HEP contingency fund equal to approximately 2 percent of the hospitals' allowable cost bases. It is used to pay hospitals for increases in volumes of services, CON projects, incremental operating expenses and various other purposes subject to the approval of the RAHC Board.

In 1980, the HEP contract restricted the use of the contingency fund to volume and CON adjustments. After 1980, the fund split equally into two sections: up to one-half for volume adjustment and CON expenses, and the balance for what is referred to as the "other" taps portion of the fund.

Each year's fund balance carries forward into the next year throughout HEP. Any unexpended monies remaining upon termination will be returned in equal parts to the hospital administrations and the contracting payors, proportionate to the original contributions to the fund.

Uses of the contingency fund—volume adjustment

The HEP contract volume adjustment formula was designed to provide hospital administrators with incentives. They are:

- Screen elective admissions to determine if they are medically required;
- To reduce length of stay;
- To replace, when medically appropriate, inpatient admissions with less costly outpatient modalities.

This is accomplished primarily by the method used to compute the inpatient volume adjustment. If admissions are less than in the base year (1978), its revenue is unaffected, enabling hospital managements to retain all inpatient revenues even though they are treating fewer inpatients. If a hospital experiences an increase in admissions over the base year, it must absorb the variable cost per admission of the first 2 percent increase. That is, the hospital will receive a volume adjustment for only those admissions beyond 102 percent of base year admissions. For admissions in excess of 102 percent, a hospital receives 40 percent of the base year's cost per admission (adjusted for inflation) from the contingency fund, which is a conservative estimate of variable costs.

Volume adjustment for outpatient services

For outpatient services, the intent of the volume adjustment will not reward or penalize a hospital for increases or decreases in the number of patients treated. Thus, there is no corridor for the outpatient volume adjustment. The adjustment may add to, or reduce, a hospital's revenue. For each added (or decreased) outpatient visit, lab test, X-ray procedure during the base year (adjustments are calculated departmentally), the hospital receives or contributes to the contingency fund an adjustment equal to 60 percent of the 1978 cost per unit adjusted for inflation.

RAHC review of all Certificate-of-Need projects is provided in its bylaws because of its goal of improving coordination of hospital planning. While RAHC's role is advisory to the Finger Lakes Health Systems Agency (FLHSA), the influence of RAHC review has been significantly strengthened since implementation of the HEP experiment due to the changes in new services' financing.

The HEP contract requires that the net incremental operating expenses of all CON-approved projects implemented after Jan. 1, 1980, be financed from the HEP contingency fund. After initial financing, these incremental expenses are added to the hospital's allowable cost base.

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Since all expenditures from the contingency fund must be approved by the RAHC board, the HEP contract has given added weight to local planning efforts. A hospital administration could, conceivably, receive state approval for a project rejected by RAHC. However, it would implement the project without certainty of adequate revenue for related increased operating expenses for the duration of the experiment.

The definition of the financial effect of CON projects is negotiated between RAHC and hospital staffs. The hospital submits an estimate of the cost effect of a project; RAHC staff reviews the assumptions underlying that estimate and resolves any issues with the hospital's staff. The final estimate is subjected to further analysis by committees and, ultimately, the RAHC board, where authorization to expend project-related contingency fund monies must occur prior to disbursements.

Three categories of costs are reviewed: 1) capital costs associated with buildings and fixtures, 2) capital costs associated with major movable equipment, and 3) incremental operating expenses. Depreciation and interest on buildings and fixed equipment is paid based on actual costs. For this reason, these projects are assessed on their merits in terms of community need. A simple review for reasonableness of financing and construction costs, relative to the scope of the project, is deemed sufficient.

Because HEP payment for depreciation on movable equipment results from trending forward this cost component from the base year, a hospital's revenue is fixed regardless of the addition of movable equipment. Because the administration is at risk for financing new equipment, only a cursory review of equipment costs occurs. Nonetheless, through the review of such applications by RAHC committees, opportunities for volume discounts (when several facilities are planning purchases of similar equipment) become apparent and can be pursued.

A more detailed review occurs for projects involving increased hospital operating expenses. Since the initial financing of these projects is from the contingency fund, it is RAHC's fiduciary responsibility to assure that these funds are spent appropriately. As a result, prior to presentation of an authorization request to the RAHC Board, such projects and their incremental costs are reviewed[g] to assure that project fiscal issues are raised and resolved. The RAHC board then votes on the project to authorize the payment for financing the project.

"Other" contingency fund taps

In 1981 and thereafter, one-half of the contingency fund may be used in connection with "other taps." These "other taps" were defined by criteria established by RAHC during 1980 to provide incentives for cost-effective resource management and may be applied to case mix adjustments, information system expenses, unforeseen events and oth-

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g. RAHC's review structure is extensive: The board of RAHC consists of two representatives from the boards of each member hospital and two representatives from the University of Rochester School of Medicine and Dentistry; typically, these representatives are past or present leaders within their institutions. The Medical Advisory Committee of RAHC consists of two members assigned by each hospital from its clinical management/medical staff structure; typical representatives might be the medical director of those hospitals having such positions coupled with a present or past president of the hospital's medical staff or a full-time chief of a clinical department. The Administration Committee consists of the chief executive officer of each member hospital.
Additional board committees include the Finance Committee (each hospital board's Finance Committee chairman, headed by the treasurer of RAHC), the Executive Committee, and the Planning Committee. Other committees drawn from among hospital administrative personnel include the Fiscal Directors' Committee (each hospital's chief fiscal officer), the Operations Committee (each hospital's chief operating officer), the Planning Directors' Committee (each hospital's chief planner), and so on.

Rep. Barber B. Conable, Jr. (R-N.Y.) (far right), senior Republican on the House Ways and Means Committee, discusses the HEP program with (from left) Stephen Waite, board member, and William D. Ryan, board chairman; James A. Block, M.D., president, and Donna Regenstreif, Ph.D., vice president, RAHC.

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er situations as determined by the RAHC board. Currently, a portion of these funds is supporting development of a data base that will combine all hospitals' medical records, billings, and cost information. This data base should give hospital managers planning and management information not previously obtainable in a timely fashion on a community wide basis.

Also, a methodology is being developed to pay hospitals for changes in case complexity. This refers not only to case mix but also to changes in intensity and/or medical practice patterns.

Proposals submitted by participating hospital administrations, the university medical center, and others in the healthcare community, have been received and are being given funding consideration. These projects would analyze issues or support efforts to enable greater understanding of factors involved in success under HEP. Initial funding decisions are expected later this year.

First-year results under HEP

From a financial viewpoint, HEP was intended to accomplish two goals: 1) contain the rate of increase in hospital expenditures on a voluntary basis, and 2) restore solvency to a hospital system experiencing a rapidly deteriorating financial condition.

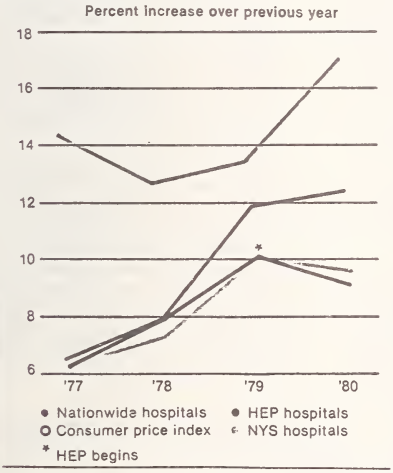
In 1980, the Rochester hospitals' collective increase in expenditures over 1979 was 9.1 percent. This compares favorably with expense movement under traditional reimbursement regulation elsewhere in the state and is in sharp contrast to the estimated 17 percent by which hospital expenditures expected to rise nationally during 1980, as shown in Exhibit 3.

The predictable revenues and reduced collection periods provided under HEP combined with the hospital administrators' efforts to contain costs have created the potential for Rochester area hospitals to generate capital to meet future requirements thereby better meeting the health needs of the community. Exhibit 4 presents some financial indicators demonstrating improvements under HEP.

Moreover, the hospitals' unrestricted cash increased by more than $10 million, nearly a 50 percent increase during the year. This favorable influence aided non-operating revenue and net income due to the high interest rates available in 1980 for short-term investments.

It is not expected that each subsequent year of the experiment will yield such dramatic positive changes. Nonetheless, since the hospitals' revenues are not predictable, hospital managers should be able to retain the first year's benefits and improve their financial condition further through prudent management during the duration of the experiment.

Exhibit 3: Hospital expense trends



Other management activities stimulated by HEP

Rochester area hospitals' progress under HEP in 1980 demonstrates that appropriate payment incentives can help hospitals improve their financial standing and contain their rate of cost increase. The "crisis" atmosphere surrounding management has been reduced and an environment of fiscal predictability prevails.

Hospital executives are beginning to seek solutions to some fundamental managerial and planning concerns. They now recognize that, implicit in the search for quality care at affordable cost, a new partnership is needed among all of the key players in the hospital field: administrators, medical staffs and governing boards.

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Exhibit 4: Hospital financial indicators

	HEP hospitals		Industry* average
	1980	1979	
Current ratio (current assets ÷ current liabilities)	1.53	1.36	1.90
Average collection period in days	40.5	52.5	59.4
Net operating margin (net operating income ÷ by operating revenue)	.012	(.01)	.023

*Industry averages per the Hospital Financial Management Association-Financial Analysis Service.

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Planning must be guided by clinical forecasting because, in the course of caring for their patients, physicians hold the key to consumption of most hospital resources. Necessary services must be available within each hospital structure and as part of a community wide system. Governing bodies responsible both for quality of care and the hospital's level of financial performance need information which integrates clinical and financial data.

In anticipation of these needs, the HEP contract provided for the acquisition of a more complete set of financial, utilization, clinical and statistical information than ever has been available to a community's hospitals. Technical development to enable the production of routine management reports for each hospital administration to assist in its quality assurance, utilization review and budgeting functions has been completed. This year, hospital managers will receive the initial products of this merged clinical/fiscal data system based on 1980 experience. These reports will enable analysis of patterns of utilization and the medical practice patterns underlying demands for beds and support services. With these and other types of analyses as management tools, hospitals, physicians, and health planners can, for the first time, make management decisions which are directly based upon the hospital's patient care products and future projections of these.

Rochester's progressive healthcare community is acting as a laboratory for the nation in a significant cooperative reimbursement experiment . . . It may well provide a new direction in hospital financing. I can assure you it's being closely watched.
Rep. Barber B. Conable Jr.

In the years to come, major efforts will focus on further development of the data base and enhancements of the reporting capabilities. Other important ongoing RAHC activities include providing a forum for sharing emerging positive experiences to implement this new information, educational programs and technical assistance. Changes in undergraduate and graduate medical education curricula are expected as clinical knowledge becomes understood.

The 1980 results were assisted by various financially focused management reports called *"Financial Analyses."* These were completed for each participating hospital administration. Using comparable cost data from Maryland and RAHC hospitals, their purpose is to identify areas within a hospital with apparent potential for cost savings when compared to hospitals with similar characteristics.[h]

Hospital managers have been able to receive comparative reports through independent agencies or associations for some time. The major difference (other than methodology) between such reports and the RAHC financial analysis is the presentation process. Discussions occur (with the full cooperation of each hospital staff), after presentations to the RAHC board and finance committee, that enable each to learn and share the benefits of the information in a constructive, non-punitive atmosphere. An important goal is to focus hospital board members' understanding and attention on potential problem areas within an institution and to obtain the board's support for administration-initiated actions in follow-up.

Development of financial analyses has also aided in reviewing the budgets of the hospitals, provided for in RAHC's bylaws. The hospital administrations reached a consensus on budget review criteria such that, if a hospital facility did not meet one or more of the criteria, a detailed RAHC review of the hospital's budget would occur. The criteria selected included net patient revenue, expense movements and operating income tests. The detailed review was carried out using formats similar to the financial analysis.

However, instead of making comparisons with other hospital administrations, the hospital's 1978 costs (trended to 1981 levels) and the 1981 budget were compared. The purpose was to identify areas in which cost increases exceeded amounts allowed by HEP trend factors. Presentation of the budget reviews were done in the same context as the financial analyses, and were agreed to be of benefit to institutions in understanding the long-term effects of management decisions as well as factors outside of traditional direct management control, such as changes in case complexity or patterns of medical practice.

As a result of negotiations in the fall of 1980 (which led to the extension of the initial three-year term of the experiment to a five-year HEP), the extension contract was worded to provide for a mid-cycle review of the program's influence on payors and hospitals based upon five board criteria: rate of cost increase; hospital industry solvency; development and use of information system; effectiveness of hospital care; board and medical staff involvement. Clearly, all parties thus recognize the broader managerial implications of the program and are united in their determination to effect positive changes in these multiple sectors with the stimulus provided by positive incentives and predictable revenue under HEP. □

h. The Financial Analysis Methodology was developed cooperatively with hospital chief financial officers and is detailed in "RAHC Financial Analyses," Rochester Area Hospitals' Corporation, 1980.

Senator DURENBERGER. Is that it?

Dr. REGENSTREIF. That's it.

Senator DURENBERGER. Right on the button. It is incredible.

Thank you very much.

I wonder if you could describe a little bit for me and for anybody who hasn't read your statement in full, a little bit more of the marketplace in Rochester. I think there are nine hospitals that are part of this project; is that correct?

Mr. RYAN. That is correct. This is 100 percent of the hospitals.

Senator DURENBERGER. What is the mix between public, nonprofit?

Mr. RYAN. They are all not-for-profit hospitals, essentially. We did away with the municipal hospitals some years ago. So that with the exception of some 60 beds in a county institution which is a part of our organization, it is essentially a not-for-profit system.

Senator DURENBERGER. Are there any active HMO's operating in the area?

Mr. RYAN. A number of them. I think we have three at the moment; is that correct?

Dr. REGENSTREIF. There are three HMO's. One is a Kaiser-type group practice model. One is an individual practitioner association sponsored by the Amalgamated Clothing Workers, and one is a network type of HMO that does its major delivery out of a network of community health centers, several of which are hospital based.

Senator DURENBERGER. At the time of this project and its start in 1978, or whenever it was, did any of them have individual arrangements with the hospitals on hospital rates, any of the HMO's?

Dr. REGENSTREIF. No; only to the extent that New York State provides for the most favorable rates to be made available to all HMO's.

All of these three HMO's are certified by the State of New York and therefore, come under that regulation.

Senator DURENBERGER. I see. What percentage of the population now do those HMO's enroll?

Dr. REGENSTREIF. Approximately 85,000 people, which is a little over 10 percent of the employed population. There is a small medicaid, prepaid population within one of the HMO's, the network one, that has approximately 3,000 medicaid enrollees, and probably their experience is the most successful of any of the population groups within the three HMO's.

Senator DURENBERGER. Have you had enough experience to know what you are going to do in this arrangement?

I may not understand it fully. When someone runs across a major capital acquisition expense, one of the member hospitals are sort of covered in this sort of pool that is created here among the institutions.

Mr. RYAN. It is a little bit early to give you a long-term answer to that. We think we are in good shape primarily because of the fact that competition now for fancy facilities and in excess of what they need is no longer practical, because if they can't make money on them, they don't want them.

I think what we are finding out is that the hospitals today are coming in only for what they really need, and then they have to justify it to everybody else in the community. That means they

have a tough competition sitting around the table haggling with them when they come in with something that is frivolous.

While we do have built in the need for replacement of facilities in an orderly way, we now have it for the first time, with a predictable income, the ability for hospitals to project down the road for the next 5 years anyway, and know they will have a predictable income on which they can base their capital requirements.

Senator DURENBERGER. Each of the nine hospitals is still an individual entity and individual corporation and individual set of trustees, and so forth; right?

Mr. RYAN. That is correct.

Dr. REGENSTREIF. Right.

Senator DURENBERGER. Suppose one of them decides it wants to, it is growing, and I do not know Rochester, N.Y., that well, but let's say there is a growing suburban area out there that doesn't have easy access to hospital facilities and they want to put up just a primary care facility or something like that. How do you expect that would—are there eight people who would jump up and down and say, "No, you can't do that," or what?

Dr. REGENSTREIF. Not exactly. The capital financing under this experimental payment program is essentially in two categories. One deals with movable equipment and one deals with fixed equipment.

The fixed equipment component is a passthrough under HEP. Whatever moves through the RACH planning process and the certificate of need process is guaranteed our reimbursement.

The movable equipment, on the other hand, is trended forward, based on historical depreciation amounts and a trend factor sensitive to movement in the costs associated with medical equipment.

So, there is that element for major capital, but I think Mr. Ryan was referring to the volume implications which must be paid for out of a limited fund. Unless there is a significant alteration in need that can be demonstrated by an individual hospital in our area, which is not rapidly changing and is regarded as adequately served by its existing medical staff, then there would be some amount of difficulty in getting such an application through.

Senator DURENBERGER. I do not know if it is appropriate to ask in terms of financing medicare and medicaid versus the nonsubsidized health care, are decisions made within the consortium of nine hospitals that in any way disadvantages medicare financing?

Dr. REGENSTREIF. Well, I think that the major area in which medicare is likely to benefit in the future is in a much more assertive posture on the part of hospitals concerning long-term care.

Our hospital system, as a whole, meets together and spends probably 25 percent or more of its time in chief executive meetings discussing the problem relating to the fact that some 15 percent of medical-surgical beds in the community are occupied by long-term-care placement problem patients, and very frequently, heavy-care patients and so on.

We are hopeful that we will be able to work with HCFA and with the State of New York to develop some more innovative and flexible solutions to this problem as well and since many of those

patients have medicare as the primary insurer and medicaid as the secondary insurer, we think it will be to the benefit of both public payers to see some movement made in this regard.

Senator DURENBERGER. What is the—I am trying to think in terms of how you replicate what you are doing in other communities.

Can you identify for us what you consider to be some of the most critical aspects of this Rochester plan?

Is it the prospect of planning or the identical treatment of all payers or the New York State cost control program or what is it?

Mr. RYAN. I think that it is a very simple program. In essence, what we did is we threw out the whole traditional system which we felt was absolutely inappropriate. The incentives were in the wrong place. It was punitive. It was everything that we thought was wrong.

In its place we decided we were going to put a program that had only one set of criteria, that there would be nothing but positive incentives for effective management.

Now, that end of it is very simple. I think the concept is exportable within the limits of those communities that desire to work together to cut their costs of hospitalization. Because what has happened now, the hospitals are terribly anxious to take this limited pool of money which is considerably less than they would have if they were operating in other parts of the country, and they can still make money with it, but the only way they can do it is by making sure there are not any wasteful practices. The most important thing we find coming out of this is that the physicians who are terribly involved in this, I would say it is not a completely physician-oriented thing, but it is very heavily oriented to the physician, is that for the first time in the history of the practice of medicine in this country, any way, the physicians are finding out what the ramifications of their daily decisions are.

The amazing progress that is coming in this area is just fantastic. The physicians are just extremely pleased with the fact that they are finding out what they are doing. They are finding out where they are creating ridiculous cost increases.

The evidence is just so plain to everybody that this is a much better system. I think the prospects of exploiting it would be excellent.

Senator DURENBERGER. Well, I thank you very much for your testimony, and for what you are doing in Rochester. I hope you will have a chance to visit again sometime.

Thank you both very much.

Mr. RYAN. Thank you.

Dr. REGENSTREIF. Thank you.

[The prepared statements follow:]

Rochester Area
Hospitals' Corporation
220 Alexander Street, Suite 608
Rochester, New York 14607 716-546-3280

TESTIMONY

BY

WILLIAM D. RYAN
CHAIRMAN, BOARD OF DIRECTORS

AND

DONNA I. REGENSTREIF, PH.D.
EXECUTIVE VICE PRESIDENT

TO

UNITED STATES SENATE
FINANCE SUBCOMMITTEE ON HEALTH
HEARING ON HCFA DEMONSTRATIONS

THURSDAY, JULY 30, 1981

- The Rochester Area Hospitals' Corporation, which is responsibile for the implementation of an area-wide hospital payment demonstration, represents a locally controlled, voluntarily initiated, positive response to punitive aspects of reimbursement policies and regulations.

- The Hospitals' Experimental Payments Program was made possible by waivers of traditional reimbursement principles governing payments by Medicare and Medicaid and provides the community's hospitals with positive incentives to enhance the quality and cost effectiveness of hospital services.

- During its first full year of operation, hospitals paid in accordance with HEP reimbursement principles achieved the lowest rate of cost increase achieved in any area in the nation. Expenses increased 9.1% for RAHC hospitals, compared with an estimated 10% elsewhere in New York State and 17% for the nation as a whole. This was accomplished in the absence of punitive regulation, through the substitution of positive incentives.

- HEP hospitals improved their financial condition, particularly noteworthy in comparison with other hospitals in New York State, by their tight control of costs coupled with stable and predictable revenues. This was accomplished without compromise to educational programs, public access to hospital care, or dilution of high standards of quality.

- The increasing problem of patients requiring long-term care occupying hospital beds has led the Corporation to seek additional HCFA waivers to solve this problem. The long-term care capitation demonstration proposed to the Health Care Financing Administration with the endorsement of the New York State Medicaid Agency would put hospitals at risk financially for long-term care placement of patients while providing them with flexibility and incentives to maximize the probability of improved patient function as economically as possible.

The Rochester Area Hospitals'
Experimental Payments Program

I. Background and Introduction

The Rochester Area Hospitals' Corporation (RAHC) was incorporated as a not-for-profit organization in July, 1978, after years of cooperative planning activities[1] among the area's hospitals, their Boards, and medical staffs. RAHC's Board includes two Board representatives from each of the nine hospitals in the two-county area, which includes metropolitan Rochester, and two Board representatives from the University medical school. The founding hospitals support RAHC through payment of dues allocated in proportion to each hospital's budget.

The Rochester area has 23% fewer beds per thousand population than the national average (3.4 in the Rochester area vs. 4.4 nationally), and its Blue Cross-covered population (about 80% of local employees) has hospital usage rates (under 550 days per thousand in 1979) which are among the lowest experienced by Blue Cross Plans' subscriber populations. Despite such background factors contributing to economy in health care costs, the solvency of Rochester hospitals was seriously threatened as the result of rigorous New York State hospital cost containment policies that limited payments to hospitals from Blue Cross and Medicaid initially, and eventually brought hospital charges under State control as well.

RAHC's initial task was to develop a reimbursement alternative to test the assumption that a community, through voluntary local control and accountability, could simultaneously enhance

its hospital system's excellence and control its rate of cost increase. Thus, RAHC's mission is to maintain and enhance the community's hospital system; control the rate of cost increase of hospital services, thereby ensuring the availability of needed hospital services in an era of increasing constraint on resources; facilitate local decision-making through enhanced communication and coordination; and maximize the cost-effectiveness and benefit to the community of hospital services provided and planned.

The Hospitals Experimental Payments (HEP) Program was developed to help achieve these goals. Its development was supported by dues from RAHC hospitals and a grant from The John A. Hartford Foundation of New York City. A contract was developed specifying the terms for a new hospital payment methodology consisting of a proposed prospectively determined community-wide cap on revenue for a three-year period to begin January 1, 1980. It was signed by all of the acute care hospitals in the area and by the Rochester Hospital Service Corporation (Blue Cross) and then forwarded to the State of New York, where it received approval from the Office of Health Systems Management and the Department of Social Services (Medicaid). The U.S. Health Care Financing Administration approved the project in December, 1979, and granted a waiver of Medicare and Medicaid reimbursement principles. HEP was implemented on January 1, 1980, and its term extended for an additional two years (through December 31, 1984) with the agreement of all contracting parties at the end of 1980.

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Nine hospitals are participating in the RAHC experiment; they range from two hospitals of under 100 beds in semi-rural communities to a tertiary care University Medical Center with over 700 beds. In 1980, on entering the payment experiment, their aggregate expenses were in excess of $270 million. They employed nearly 10,000 people in support of their patient care activities and annually trained over 600 residents in a variety of medical education programs. They serve a population of one million[2] and constitute the Northern Sub-Area of the Finger Lakes Health Systems Agency planning region.

Prior to HEP, payment mechanisms for these hospitals was governed by government regulations that were sometimes contradictory, did not permit hospitals to accurately predict their income, and invariably resulted in hospitals losing revenue when cost reductions were achieved. Under these circumstances, hospitals found it difficult to establish policies that could enhance patient care and maintain financial solvency. Moreover, their ability to budget and plan effectively was adversely affected by frequent changes in reimbursement rules and regulations. By 1978, the solvency of the hospitals system in Rochester and elsewhere in the State of New York was seriously threatened. Some hospitals had liquidated a portion of their endowment funds to underwrite routine activities.

Rochester hospital trustees determined to join together to develop a positive alternative to these difficulties; on a voluntary basis, they would demonstrate their commitment to a local system of SELF-CONTROL. This system required a predictable

fiscal environment to succeed. The HEP program was further combined with information systems to enable community-wide planning in response to community need and ongoing efforts to assure quality and evaluate cost-effectiveness of hospital services.

The provision of needed high quality services presumes an understanding of the hospitals' major products and the association between patterns of resource use (or medical practice) and treatment costs. HEP offers predictable levels of revenue in support of the hospitals activities. Concurrently, it creates a need for a clear statement of expected patient resource usage in order for a hospital to effectively plan, budget, and monitor its performance. Thus, one important facet of RAHC activities has been the integration of all hospitals' financial, billing, and discharge abstract information into a routine management reporting system. Individual hospitals use these reports in planning, management, and quality assurance functions. On a community-wide basis, these reports assist in overall hospital system planning. HEP's payment approach thus offers hospitals totally different financial incentives plus a unique management and planning opportunity.

II. General Features of HEP

HEP's general features are to promote the effective and efficient delivery of hospital services in the Rochester area and to maintain the solvency of the participating hospitals. HEP is predicated on the idea that a major cause of inflation in

hospital costs is the faulty design of health reimbursement systems. The incentives inherent in traditional reimbursement systems, and New York's early efforts at State-wide regulation, do not promote these purposes. HEP encourages hospital cost containment through the introduction of appropriate incentives in the hospital financing system that affect both inpatient and outpatient services.[3]

These new incentives are, for the most part, the results of two features of the HEP system:

(1) Payments to each hospital are based, after the first year of the program, on that hospital's preceding year's payments without regard to its incurred costs. Cost savings realized by the hospital thus accrue to its benefit throughout the program.

(2) Total revenue available to the community's hospitals is determined in advance of each year of the program. The available revenue covers all of the hospitals' expenses, including incremental operating expenses associated with approved Certificate-of-Need (CON) projects, increases in volumes of services, and costs associated with unforeseen events. This feature gives the hospitals incentives to work together to avoid unnecessary duplication of service, while preserving the autonomy of each hospital.

HEP addresses two principal causes of hospital cost inflation:

(1) The Volume Problem, i.e., the incentives of traditional reimbursement to reward high rates of admission, long lengths of stay, and increasing resource use per admission;

(2) The Planning Problem, i.e., planning agencies' approval of projects under CON regulation neither reflects an accurate assessment of financial reasonableness nor links projected expenses with actual experience.

HEP's response to each of these issues is more diverse and clearly delineated than in any other hospital payment system in the United States today. These responses:

(1) Volume: Under HEP, hospitals are compensated for increases in admissions according to a formula designed to discourage marginal admissions and to promote increased use of outpatient services. All payment for additional services is drawn from the Contingency Fund; thus hospitals are collectively at risk for unwarranted increases in volumes of service. Further, there is a 2% corridor before increased admissions are paid and a conservative marginal cost factor (40%) applied to payments for increased inpatient admissions. Further, hospitals receive no compensation for increased resource use per patient.

(2) Planning: The operating costs of CON-approved projects are drawn from the community-wide Contingency Fund and are subject to negotiation between RAHC and the hospitals' financial staffs. Thus, the hospitals are collectively at risk for planning decisions and their associated costs; and there is expertise and incentive to improve cost-effectiveness.[4]

III. Detailed Description of HEP Contract Provisions

HEP is a prospective payment system that uses the hospitals' 1978 allowable costs (defined in accordance with Medicare principles) as the basis for establishing payment levels for the five-year term of the experiment. Two calculations are fundamental to the system: 1) an overall limit on the annual net patient revenue for all hospitals called the "Final Dollar Amount", and a limit on 2) an individual hospital's annual net patient revenue, which is the hospital's "Final Allowable Cost Base".

Final Dollar Amount

The Final Dollar Amount, sometimes referred to as the "total revenue cap", was calculated for 1980 by projecting each hospital's 1978 base year costs (adjusted for the incremental operating costs of CON-approved projects implemented between the base year and 1980) to the rate year, using inflation or "trend" factors to account for price increases in the goods and

FIGURE I

Computation of 1980 Final Dollar Amount

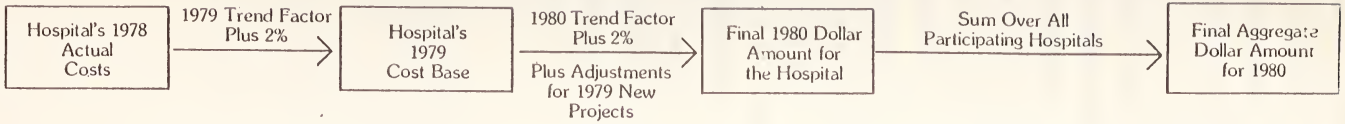
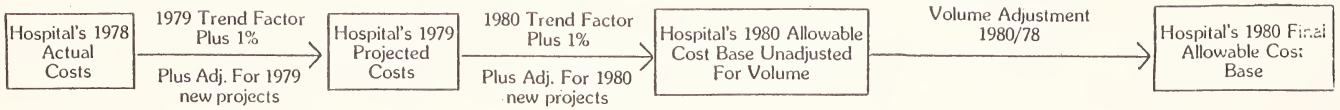

Hospital's 1978 Actual Costs
1979 Trend Factor Plus 2%
Hospital's 1979 Cost Base
1980 Trend Factor Plus 2%
Plus Adjustments for 1979 New Projects
Final 1980 Dollar Amount for the Hospital
Sum Over All Participating Hospitals
Final Aggregate Dollar Amount for 1980

FIGURE II

Computation of a Hospital's 1980 Final Allowable Cost Base


Hospital's 1978 Actual Costs
1979 Trend Factor Plus 1%
Plus Adj. For 1979 new projects
Hospital's 1979 Projected Costs
1980 Trend Factor Plus 1%
Plus Adj. For 1980 new projects
Hospital's 1980 Allowable Cost Base Unadjusted For Volume
Volume Adjustment 1980/78
Hospital's 1980 Final Allowable Cost Base

services that hospitals use and a 1% annual provision for working capital. In 1981 and subsequent years, the Final Dollar Amount is based on the preceding year's Final Allowable Cost Bases (which are explained below), exclusive of adjustments for volume, plus an amount for inflation.

In addition, 2% is added each year to the trend factors to allow payment for increased volumes of hospital services, incremental operating expenses associated with CON projects, unforeseen events, and various other special projects consistent with the incentives of HEP. This 2% of a hospital's Final Dollar Amount is paid into a "Contingency Fund" which is held and disbursed by RAHC. Any balance remaining in the fund at the conclusion of the experiment is shared equally by the hospitals and the payors, and distributed among them in proportion to their contributions to the fund.

The sum of all the Final Dollar Amounts of the individual hospitals is called the "Final Aggregate Dollar Amount". This is the maximum amount of net patient revenue that all the participant hospitals may share in a given year and is diagrammed in Figure I.

Final Allowable Cost Base

While the Final Dollar Amount limits the amount the hospital system as a whole may receive, the Final Allowable Cost Base defines the revenue an individual hospital can receive for services to patients, since it is the base on which the liabilities of the contracting payors are established. It is also a cap on revenue because, a hospital's total net patient

revenue from all sources in excess of the Final Allowable Cost Base, must be paid into the Contingency Fund. Any excess revenue thus accrues to the system as a whole, and not to an individual hospital. This aspect of the Final Allowable Cost Base extends the revenue cap to all classes of payors, not only the three contracting payors.

Calculation of the Final Allowable Cost Base, as of the Final Dollar Amount, uses 1978 base year costs with adjustments for CON projects and is diagrammed in Figure II. In 1979 and 1980 only, the hospitals were provided a 1% increase over the trend factors for working capital. Hospitals' Final Allowable Cost Bases are also increased by payment for increases in service volumes according to contract formula.

Trend Factor Methodology

A policy common to all prospective payment systems and used by all hospital rate-setting agencies is not to put hospitals at risk for cost increases beyond their control, e.g., those associated with general economic inflation. The combinations of goods and services consumed by hospitals is different from that of other sectors of the economy. The impact of inflation on hospitals is not accurately reflected in the indices developed by the Bureau of Labor Statistics(BLS) or other economic forecasters. In order to implement HEP, a system was developed called "The Trend Factor Methodology" to measure more precisely the impact of inflation on hospital costs.

This methodology separates each HEP hospital's 1978 costs into 50 components. These include wages, benefit categories (i.e., FICA, medical insurance, etc.), food, medical supplies (i.e., blood products, drugs, X-ray film, etc.), depreciation on movable equipment, and depreciation on building and fixed equipment. Each of these cost components is assigned a weight which is its percentage of total costs. A proxy is assigned to each of these weights which estimates the price movement in that cost component for a stated time period. Some of these proxies are involved in the computation of the Consumer Price Index (CPI) and other indices published by BLS. For example, the subcomponent of the CPI which measures increases in food prices is the proxy used for the food cost component. Proxies are specified in the HEP contract and are calculated or estimated by RAHC at given intervals each year.

The overall Trend Factor for each hospital is the sum of the products of the proxy multiplied by the weight for each cost component.

The HEP Trend Factor differs from the methodology in the prior payment formula in three ways:

(1) The HEP Trend Factor is hospital-specific; i.e., the weights used in the computations are those of an individual hospital as opposed to an average of many hospitals;

(2) The proxy for depreciation on buildings and fixtures is the actual movement in this cost category from one year to the next; i.e., if a hospital's

depreciation on building and fixed equipment increased 10% in 1980 over 1979, then the proxy used is 10%;

(3) The proxy for wages and salaries (about 50-60% of a hospital's total costs) is related to the weighted average of actual salary increases given to production workers and working supervisors in the Rochester area. This ties the hospital's allowance for salary increases to the experience of the local labor market.

Apportionment of the Allowable Cost Base

The Allowable Cost Base defines the liabilities of the contracting payors. Distribution of the Allowable Cost Base among the contracting payors is accomplished using standard Medicare apportionment techniques. Patient days by payor class is used to distribute routine costs, and the ratio of charges-to-charges-applied-to-costs (RCCAC) is used to apportion ancillary and outpatient costs among contracting payors.

Under traditional New York State reimbursement, Blue Cross and Medicaid reimburse hospitals according to the average cost per day for all patients. This has led to shortfalls in reimbursement and cross-subsidization among payors. By applying the same system to all payors, this cross-subsidization should be eliminated under HEP. Payments to hospitals are made on a concurrent basis similar to Periodic Interim Payments (PIP) under Medicare. Interim payor liabilities are established using the latest audited apportionment statistics to calculate

weekly payments.

It should be pointed out that the first year's impact of the change to the RCCAC methodology, the concurrent payments and the provision of the Contingency Fund had the impact of increasing Blue Cross' liabilities to the hospitals 6 to 7 per cent over the trend factor. However, future increases in Blue Cross payments should be limited to approximately the trend factor.

The Contingency Fund

The hospitals' weekly payments include an amount for the HEP Contingency Fund equal to approximately 2% of the hospitals' Allowable Cost Bases. It is used to pay hospitals for increases in volumes of services, CON projects, incremental operating expenses, and various other purposes subject to the approval of the RAHC Board.

In 1980, the HEP contract restricts the use of the Contingency Fund to volume and CON adjustments. After 1980, the Fund is split equally into two sections: up to one-half for volume adjustment and CON expenses, and the balance for what is referred to as the "other" taps portion of the Fund. Each year's Fund balance carries forward into the next year throughout HEP; and any unexpended monies remaining upon termination will be returned in equal parts to the hospitals and the contracting payors, proportionate to the original contributions to the Fund.

USES OF THE CONTINGENCY FUND

Volume Adjustment

The HEP contract volume adjustment formula was designed to provide hospitals with incentives to: screen elective admissions to determine whether or not they are medically required; reduce length of stay; and replace, when medically appropriate, inpatient admissions with less costly outpatient modalities. This is accomplished primarily by the method used to compute the inpatient volume adjustment. If the hospital's admissions are less than in the base year (1978), its revenue is unaffected, enabling hospitals to retain all inpatient revenues even though they are treating fewer inpatients. If a hospital experiences an increase in admissions over the base year, it must absorb the variable cost per admission of the first 2% increase. That is, the hospital will receive a volume adjustment for only those admissions beyond 102% of base year admissions. For admissions in excess of 102%, a hospital receives 40% of the base year's cost per admission (adjusted for inflation) from the Contingency Fund, which is a conservative estimate of variable costs.

For outpatient services, the intent of the volume adjustment is neither to reward nor to penalize a hospital for increases or decreases in the number of patients treated. Thus, there is no corridor for the outpatient volume adjustment, and the adjustment may add to, or reduce, a hospital's revenue. For each added (or decreased) outpatient visit, lab test,

x-ray procedure etc. over the base year (adjustments are calculated departmentally), the hospital receives or contributes to the Contingency Fund an adjustment equal to 60% of the 1978 cost per unit adjusted for inflation.

Incremental Operating Expenses for CON-Approved Projects

RAHC review of all Certificate-of-Need projects is provided for in its bylaws because of its goal of improving coordination of hospital planning. While RAHC's role is advisory to the Finger Lakes Health Systems Agency (FLHSA), the impact of RAHC review has been significantly strengthened since implementation of the HEP experiment because of the changes in financing of new services. The HEP contract requires that the net incremental operating expenses of all CON-approved projects implemented after January 1, 1980, be financed from the HEP Contingency Fund. After initial financing, these incremental expenses are added to the hospital's Allowable Cost Base. Since all expenditures from the Contingency Fund must be approved by the RAHC Board, the HEP contract has given added weight to the local planning effort. A hospital could, conceivably, receive State approval for a project rejected by RAHC. However, it would implement the project without certainty of adequate revenue for related increased operating expenses for the duration of the experiment.

The definition of the financial impact of CON projects is negotiated between RAHC and hospital staffs. The hospital submits an estimate of the cost impact of a project; RAHC staff reviews the assumptions underlying that estimate and resolves

any issues with the hospital's staff. The final estimate is subjected to further analysis by committees and, ultimately, the RAHC Board, where authorization to expend project-related Contingency Fund monies must occur prior to disbursements.

Three categories of costs are reviewed: 1) capital costs associated with buildings and fixtures, 2) capital costs associated with major movable equipment, and 3) incremental operating expenses. Depreciation and interest on buildings and fixed equipment is paid based on actual costs. For this reason, these projects are assessed on their merits in terms of community need. A simple review for reasonableness of financing and construction costs, relative to the scope of the project, is deemed sufficient.

Because HEP payment for depreciation on movable equipment results from trending forward this cost component from the base year, a hospital's revenue is fixed regardless of the addition of movable equipment. Because the hospital is at risk for financing new equipment, only a cursory review of equipment costs occurs. Nonetheless, through the review of such applications by RAHC committees, opportunities for volume discounts (when several hospitals are planning purchases of similar equipment) become apparent and can be pursued.

A more detailed review occurs for projects involving increased hospital operating expenses. Since the initial financing of these projects is from the Contingency Fund, it is RAHC's fiduciary responsibility to assure that these funds

are spent appropriately. As a result, prior to presentation of an authorization request to the RAHC Board, such projects and their incremental costs are reviewed[5] to assure that project fiscal issues are raised and resolved. The RAHC Board then votes on the project to authorize the payment for financing the project.

"Other" Contingency Fund Taps

In 1981 and thereafter, one-half of the Contingency Fund may be used in connection with "other taps". These "other taps" were defined by criteria established by RAHC during 1980 that, for the most part, provide incentives for cost-effective resource management and may be applied to case mix adjustments, information system expenses, unforeseen events, and other situations as determined by the RAHC Board. Currently, a portion of these funds is supporting development of a data base that will combine all hospitals' medical record, billing, and cost information. This data base should give hospitals planning and management information not previously obtainable in a timely fashion on a community-wide basis.

Also, a methodology is being developed to pay hospitals for changes in case complexity. This refers not only to case mix but also to changes in intensity and/or medical practice patterns.

Proposals submitted by participating hospitals, the University Medical Center, and others in the health care community, have been received and are being given funding consideration. These projects would analyze issues or support efforts to enable greater understanding of factors

FIGURE III

Hospital Expense Trends
Percent Increase Over Previous Year

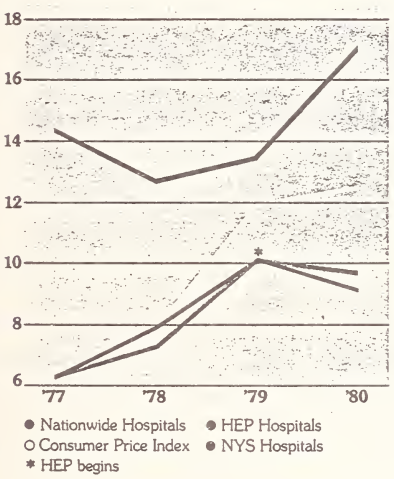


FIGURE IV

Hospital Financial Indicators

	HEP Hospitals 1980	HEP Hospitals 1979	Industry Average[6]
Current Ratio (Current Assets ÷ Current Liabilities)	1.53	1.36	1.90
Average Collection Period in Days	40.5	52.5	59.4
Net Operating Margin (Net Operating Income ÷ by Operating Revenue)	.012	(.01)	.023

involved in success under HEP. Initial funding decisions are expected later this year.

First-Year Results Under HEP

From a financial viewpoint, HEP was intended to accomplish two goals: 1) contain the rate of increase in hospital expenditures on a voluntary basis, and 2) restore solvency to a hospital system experiencing a rapidly deteriorating financial condition.

In 1980, the Rochester hospitals' collective increase in expenditures over 1979 was 9.1%. This compares favorably with expense movement under traditional reimbursement regulation elsewhere in the State and is in sharp contrast to the estimated 17% by which hospital expenditures are expected to rise nationally during 1980, as shown in Figure III.

The predictable revenues and reduced collection periods provided under HEP combined with the hospitals' efforts to contain costs have created the potential for Rochester area hospitals to generate capital to meet future requirements thereby better meeting the health needs of the community. Figure IV below presents some financial indicators demonstrating improvements under HEP.

Moreover, the hospitals' unrestricted cash increased by over $10 million, nearly a 50% increase during the year. This favorable impact aided non-operating revenue and net income due to the high interest rates available in 1980 for short-

term investments.

It is not expected that each subsequent year of the experiment will yield such dramatic positive changes. Nonetheless, since the hospitals' revenues are not predictable, hospitals should be able to retain the first year's benefits and improve their financial condition further through prudent management during the duration of the experiment.

Other Management Activities Stimulated by HEP

Rochester area hospitals' progress under HEP in 1980 demonstrates that appropriate payment incentives can help hospitals improve their financial standing and contain their rate of cost increase. The "crisis" atmosphere surrounding management has been reduced, and an environment of fiscal predictability prevails.

Hospitals are beginning to seek solutions to some fundamental managerial and planning concerns. They now recognize that, implicit in the search for quality care at affordable cost, a new partnership is needed among all of the key players in the hospital Field: administrators, medical staffs, and governing boards. Planning must be guided by clinical forecasting because, in the course of caring for their patients, physicians hold the key to consumption of most hospital resources. Necessary services must be available within each hospital and as part of a community-wide system. Governing bodies responsible both for quality of care and the hospital's level of financial performance need information which integrates

clinical and financial data.

In anticipation of these needs, the HEP contract provided for the acquisition of a more complete set of financial, utilization, clinical, and statistical information than has ever before been available to a community's hospitals. Technical development to enable the production of routine management reports for each hospital to assist in its quality assurance, utilization review, and budgeting functions has been completed. During 1981, hospitals will receive the initial products of this merged clinical/fiscal data system based on 1980 experience. These reports will enable analysis of patterns of utilization and the medical practice patterns underlying demands for beds and support services. With these and other types of analyses as management tools, hospitals, physicians, and health planners can, for the first time, make management decisions which are directly based upon the hospital's patient care products and future projections of these.

In the years to come, major efforts will focus on further development of the data base and enhancements of the reporting capabilities. Other important ongoing RAHC activities include providing a forum for sharing emerging positive experiences in using this new information, educational programs, and technical assistance. Changes in undergraduate and graduate medical education curricula are expected as clinical knowledge becomes understood.

The 1980 results were assisted by various financially-focused management reports called "Financial Analyses". These

were completed for each participating hospital. Utilizing comparable cost data from Maryland and RAHC hospitals, their purpose is to identify areas within a hospital with apparent potential for cost savings when compared to hospitals with similar characteristics.[7]

Hospitals have been able to receive comparative reports through independent agencies or associations for some time. The major difference (other than methodology) between such reports and the RAHC financial analysis is the presentation process. Discussions occur (with the full cooperation of each hospital), after presentations to the RAHC Board and Finance Committee, that enable each to learn and share the benefits of the information in a constructive, non-punitive atmosphere. An important goal is to focus hospital Board members' understanding and attention on potential problem areas within an institution and to obtain the Board's support for administration-initiated actions in follow-up.

Development of Financial Analyses has also aided in reviewing the budgets of the hospitals, provided for in RAHC's by-laws. The hospitals reached a consensus on budget review criteria such that, if a hospital did not meet one or more of the criteria, a detailed RAHC review of the hospital's budget would occur. The criteria selected included net patient revenue, expense movements, and operating income tests. The detailed review was carried out using formats similar to the financial analysis. However, instead of making comparisons with other hospitals, the hospital's 1978 costs (trended to 1981 levels) and the 1981 budget were compared. The purpose was to identify

areas in which cost increases exceeded amounts allowed by HEP trend factors. Presentation of the Budget Reviews were done in the same context as the Financial Analyses, and were agreed to be of benefit to institutions in understanding the long-term impacts of management decisions as well as factors outside of traditional direct management control, such as changes in case complexity or patterns of medical practice.

As a result of negotiations in the fall of 1980 (which led to the extension of the initial three-year term of the experiment to a five-year HEP), the extension contract was worded to provide for a mid-cycle review of the program's impact upon payors and hospitals based upon five broad criteria: "rate of cost increase; hospital industry solvency; development and use of information system; effectiveness of hospital care; board and medical staff involvement." Clearly, all parties thus recognize the broader managerial implications of the program and are united in their determination to effect positive changes in these multiple sectors with the stimulus provided by positive incentives and predictable revenue under HEP.

A major threat to the long-term viability of the rational planning and reimbursement embodied in the above is related to increasing back-up of long-term care patients occupying acute care hospital beds. Currently, these patients approach 15% of the occupants of the community's total medical/surgical bed capacity.

As with the HEP program, a positive response has been developed and proposed to the Health Care Financing Administration for waivers under Section 1115, Title VI of the Social

Security Act. It couples the interests of the hospitals, the patients, and the payors in a single solution which embodies HMO principles. The proposed capitation system for long-term care would enable hospitals to contract with nursing home competitively with other providers of long-term care. It would grant them greater reimbursement flexibility and enable them to discharge home patients who require extensive chronic care, or obtain placement for them in nursing homes.

The result of successful development and implementation would be new incentives to improve cost-effectiveness and functional level of long-term care placement. It would enable the provision of post-hospital chronic care which is responsive to local definitions of accessibility and accountability. Experience in program implementation would provide guidance to policy-makers through acquisition of empirical data, be consistent with federal policies relating to competition and local decision-making, and would avoid the even more costly construction of additional hospital beds.

Footnotes

[1]Area-wide hospital planning dates back over four decades; early efforts are described in The Rochester Regional Hospital Council. L.S. Rosenfeld and H.B. Makover. Cambridge:Harvard University Press, 1956.

[2]The two-county population is 750,000, and the nine county re-regional referral area has a population of 1.2 million.

[3]RAHC's Chief Reimbursement Consultant in development of HEP was John S. Cook, D. Phil., former Chief Rate Analyst with the Maryland Health Services Cost Review Commission. Certain features of the Maryland system and of the MAXICAP project are to be found in the HEP program. MAXICAP was a concurrent effort to develop a regional planning and reimbursement methodology which was developed with the cooperation of HCFA, National and Rochester Blue Cross, the New York State Hospital Association, and the Finger Lakes Health Systems Agency, but was never implemented. See Sorenson, A.A., Ph.D. and Saward, E.W., M.D.; "An Alternative Approach to Hospital Cost Control: the Rochester Project"; Public Health Reports. 93:311-317, (1978.)

[4]During recent negotiations in connection with CON incremental operating expenses for increased capacity for open heart surgery, the final negotiated level of incremental expense approved by the RAHC Board was some $450,000 lower than had been originally proposed by the sponsoring hospitals.

[5]RAHC's review structure is extensive: The Board of RAHC consists of two representatives from the Boards of each member hospital and two representatives from the University of Rochester School of Medicine and Dentistry; typically, these representatives are past or present leaders within their institutions. The Medical Advisory Committee of RAHC consists of two members assigned by each hospital from its clinical management/medical staff structure; typical representatives might be the medical director of those hospitals having such positions coupled with a present or past president of the hospital's medical staff or a full-time chief of a clinical department. The Administration Committee consists of the Chief Executive Officer of each member hospital.

Additional Board committees include the Finance Committee (each hospital Board's Finance Committee Chairman, headed by the Treasurer of RAHC), the Executive Committee, and the Planning Committee. Other committees drawn from among hospital administrative personnel include the Fiscal Directors' Committee (each hospital's chief fiscal officer), the Operations Committee (each hospital's chief operating officer), the Planning Directors' Committee (each hospital's chief planner), etc.

[6]Industry averages per the Hospital Financial Management Association-Financial Analysis Service.

[7]The Financial Analysis Methodology was developed cooperatively with hospital chief financial officers and is detailed in "RAHC Financial Analyses", Rochester Area Hospitals' Corporation, 1980.

Senator DURENBERGER. Our next panel is Roger Graham, senior director of alternative delivery systems policy, National Associations of Blue Cross/Blue Shield plans, Chicago, Ill., and Richard M. Burdge, senior executive vice president and president, Life & Health Care Group, INA Corp., Philadelphia, Pa.

STATEMENT OF ROGER GRAHAM, SENIOR DIRECTOR OF ALTERNATIVE DELIVERY SYSTEM'S POLICY, NATIONAL ASSOCIATIONS OF BLUE CROSS/BLUE SHIELD PLANS, CHICAGO, ILL.

Mr. GRAHAM. I am Roger Graham. Our Blue Cross/Blue Shield plans are involved with about a third of the HMO's in the country. You just heard from a couple, Marshfield and Fallon. Those HMO's cover about a sixth of the HMO membership.

We strongly support the purpose of the proposed legislation: to provide greater access to HMO's for medicare beneficiaries on an attractive or at least an acceptable basis and accrue advantages for medicare beneficiaries.

I would like to read a few parts of our testimony, because I think the points are made more concisely in the document than I can make freehand.

Senator DURENBERGER. Go right ahead.

Mr. GRAHAM. I would like to focus on what I gather is one of the major questions before this committee: How can the Federal Government determine appropriate reimbursement levels for HMO's under medicare?

The word appropriate in the question implies that reimbursement levels would be fair for the HMO and the Federal Government and that the medicare beneficiary would be getting a reasonable range of care for the payment made by the Federal Government.

Based upon our experience with the enrollment of the elderly in general, and in HMO's in particular, I am obliged to tell you that it is extremely difficult to assure fairness in every case. The procedures suggested in the pending legislation involve the use of an adjusted average per capita cost, 95 percent of which could be paid for HMO coverage. This uses available statistics to relate to regional cost variations and creates an automatic 5 percent savings to the Federal Government.

This seems reasonable and effective but the HMO must provide the needed care. That alone establishes the cost. Fairness is a simple question of whether the payments are sufficient to cover the costs.

Actuaries may quantify judgments about the future based on pertinent information about the past. There is not much pertinent information about what happens when you enroll medicare beneficiaries in a HMO on a risk basis because very little has been done. Some of the early results are quite diverse. However, the scarcity of useful actuarial information should not stop this committee from allowing medicare beneficiaries to enroll under risk based HMO arrangements. The only way we will ever gain the experience needed to be more precise is to move ahead, build in some safety factors, and keep track of what happens and why.

As useful history accumulates and is understood, much more precise actuarial work will be possible and fairness more readily achieved.

It is important to make a beginning. Using 95 percent of the AAPCC as the basis for payment, seems prudent and reasonable in the absence of better data.

Some HMO's may be overpaid while others are underpaid and these should be largely offsetting.

In the implementation proposals I have seen, actuarial judgment is a major factor in pricing benefits.

What the HMO promises to provide in exchange for 95 percent of the AAPCC will have to be reviewed. There will be inevitably be differences of actuarial opinion and I expect a judgment factor will be negotiated.

From my long experience with Government negotiations, I expect the Government to be a tough negotiator. I would expect to see more HMO's come out short than long.

This, together with the internal HMO limitations of access and capacity seem to assure that the fiscal impact on the medicare program will not be great.

Senator DURENBERGER. Thank you.

Is that it?

Mr. GRAHAM. I had some other points, but they are in the statement.

Senator DURENBERGER. We will put them in the printed record.

Mr. Burdge.

STATEMENT OF RICHARD M. BURDGE, SENIOR EXECUTIVE VICE PRESIDENT, INA CORP.

Mr. BURDGE. Yes. Mr. Chairman, my name is Richard M. Burdge. I am senior executive vice president of the INA Corp., and president of the Life and Health Care Group.

INA is one of the Nation's largest diversified financial services company and oldest commercial organizations.

Among its health related activities, the INA Health Plan, Inc., is the largest investor-owned operator of prepaid health plans in America.

Since its entry into this field in 1978, INA's operations have grown to include nine HMO plans in five States with a total enrollment of more than 450,000 subscribers. HMO's, in our view, hold great promise for meeting the needs of older Americans.

I thank you for the opportunity to testify before the subcommittee on how the principles of market-oriented economics can be applied to the medicare program to improve the quality and cost effectiveness of health care for the elderly.

I would be remiss, however, if I first did not commend you, Mr. Chairman, and Senator Heinz, the author of the proposed Competitive Health and Medical Plan Act for your longstanding efforts to apply these principles to the Nation's health care system.

INA remains committed to the four basic principles we outlined in our testimony before the full Senate Finance Committee on March 28, 1979.

Under these principles, Federal health care programs should first encourage alternative health care plans to meet the needs of medicare beneficiaries.

They should replace the Federal Government's retroactive cost reimbursement system with prospective, fixed premium financing.

They should encourage consumer participation, cost sharing and informed choice.

Finally they should channel resources saved through these improvements into expanded coverage of benefits and services for the elderly.

Let me now summarize the specific provisions that we believe should be included in any new medicare program in order to achieve these principles.

Congress should create a new program under medicare that would enable qualified alternative health benefit plans, including State and federally qualified HMO's and insurance carriers, to compete for the Federal medicare dollar.

Medicare should finance these plans prospectively on a fixed rate premium basis which reflects competitive pricing in the marketplace, along the lines of the methodology used in the Federal employee health benefits program rather than based on the AAPCC which is inflationary and administratively burdensome.

The Government's contribution to total premium cost should be established at a level that encourages consumers to select the most efficient plan.

Participating health plans should have the flexibility to use an experienced based rating system.

Guaranteed basic benefits comparable to medicare parts A and B should be mandated by statute, but plans should have the freedom to offer additional benefits as options.

Health plans should be free to apply the difference between premium revenues and cost, to expanded benefits, additional services, investment in capital and human resource improvements, rebates in premiums or retention of profits.

Health plans should be encouraged to design coinsurance, copayments, and deductible provisions that encourage efficient utilization with emphasis on first dollar cost sharing.

Under the medicare program described above, medicare beneficiaries would truly become first-class health care citizens.

Like private paying patients, they would choose among alternative health plans and delivery systems and change plans if dissatisified with their current service.

Through such improvements to the medicare program the Federal Government will become a leader in demonstrating how marketplace economics promote efficiency, how the consumer can make responsible choices and how healthy competition will improve access to quality health care at a reasonable cost.

Thank you, Mr. Chairman.

Senator DURENBERGER. Thank you very much. I thank you for your very kind comments. I do hope I live politically, at least, for the day when the Federal Government is going to be an example to anybody on marketplace economics. But we are certainly going to keep trying.

I want to start out and deal with the AAPCC. I have Mr. Graham's statement here. The reason he is here is that I guess he has been involved—I heard the figure 10, maybe it is more, HMO's that you

have helped put together, have you not, or been involved in in some way?

Mr. GRAHAM. Yes, for the last 8 years I have been "the man on HMO's" for the Blue Shield Association.

Senator DURENBERGER. You should have prequalified your statement.

Mr. GRAHAM. Technical support, consulting and that sort of a thing. Earlier I was with the Blue Shield plan and lived through the premedicare attempts to provide health care financing for the elderly, the initiation of the medicare program, the implementation of medicare supplemental coverage and the enrollment of those people.

So, I have all these experiences. I do not have them in the same bag.

Senator DURENBERGER. I was interested when you said in effect that until we have something better that using the 95 percent of the AAPCC as the basis of payment seems prudent and reasonable.

We did hear some discussion by some of the people involved in demonstration programs there.

We just heard Mr. Burdge talk about preference for other kinds of determinations of payment. Would you just discuss that issue, particularly because you added after that, something about some HMO's are going to be overpaid and some are going to be underpaid.

The assumption would be that if that kept up very long the underpaid people would drop out and would be stuck with overpaid people and cost a lot of money.

So, if you would dig into that a little bit.

Mr. GRAHAM. I am assuming, as we talk about this, whatever we are building is going to be subject to fine tuning. That we are not going to be able to start out with a fine tuned creature, because we don't yet know enough.

But, as we learn, I am assuming we are going to be able to apply what we learned.

Looking at it from the perspective of political and fiscal doability, putting ourselves in your seats for a moment, the proposals that I have seen, seem to establish two book ends. One is, you are not going to pay more than 95 percent of the AAPCC.

The other is, you are not going to get any less for it than the present level of coverage under A and B.

So, you have established some boundaries within which you are going to try to build a program. Those boundaries create safe territory for the Federal Government in examining what they can change in search of improvement.

It is within that context that we said we thought the 95 percent seemed like a reasonable place to start.

Senator DURENBERGER. Mr. Burdge, would you tell us why you—I don't know a lot about how the FEHBP works. I assume it is a negotiated program of some kind. I think you expressed a preference for that kind of approach rather than the AAPCC. Would you discuss that?

Mr. BURDGE. Under the FEHBP the Government, as employer, pays 60 percent of the premium cost of any participating plan. The employee or the beneficiary has the freedom to choose different

plans with different coinsurance and copayments. We feel this approach should be embodied in any new form of medicare payment.

So, it is our hope that the medicare reimbursement system could be changed along these lines. We started with an estimate that perhaps the Government should pay 80 percent of the premium which would require about the same amount of copayment—which we estimate to be 14 or 15 to 20 percent—for the present medicare beneficiary.

By setting it at 80, we thought it gave a good opportunity for copayments, for deductibles and for cost sharing economics that should produce savings.

Our reasons for favoring a competitive pricing mechanism rather than one based on the AAPCC are detailed on pages 10 and 11 of our full written statement.

Senator DURENBERGER. Mr. Graham, you suggested that characteristics such as age, sex, are important in setting a rate.

You also made reference to health status. I am curious to know whether health status could be realistically assessed and considered for setting of reimbursement rate.

What are some of the problems associated with it?

Mr. GRAHAM. Well, I have done quite a bit of work in this area. There is a great body of information in the insurance industry about health status, specific impairment, particularly on the younger population.

We were appalled as we tried to apply what we understood very well, about the younger population, to the over 65 population.

It seems as though you almost never see a single diagnosis. There is a high prevalence of complicating conditions like hypertension or diabetes which, when combined with any other problem, multiplies rather than adds to the difficulties and the costs.

There are some objective things, very rough, that you can do. There seems to be a big difference in cost breaking about age 75. People 65 to 75 seem to cost substantially less than the people over 75.

You can break on such things as institutional status. Clearly, if you enroll a group of people out of a nursing home, you are going to have a different level of cost. That is objective.

But when you start trying to do it by health questionnaire—and I have spent a lot of time in that field, writing manuals, training people and so on—I am not sure we are biting off anything we can chew. I am very wary of it.

Senator DURENBERGER. Are there any other characteristics we ought to be looking at to develop?

Mr. GRAHAM. Well, I think there are a couple of things that play in the selection and antiselection business. For example, Dr. Lewis' comment about how nobody had to change doctors. He not only got a large enrollment in Marshfield, but the people who were currently under treatment were not discouraged from changing programs, because changing programs didn't mean changing doctors.

Now, a small group practice in a large community is going to involve changing doctors for a lot of people, particularly if they are exclusively prepaid. That is a deterrent to selection by people who are seeking more benefits because they are actively under care.

The problem that I see as being so thorny in this is the difficulty in predicting in advance what kind of a mix you are going to get. It is so subject to influence by marketing practices, by benefit design——

Senator DURENBERGER. May I stop you right there.

Mr. GRAHAM. Yes.

Senator DURENBERGER. On the marketing practices and benefits design.

Mr. GRAHAM. Yes.

Senator DURENBERGER. What happens with Blue Cross and Blue Shield in that area? Do you see a lot of people moving back and forth from your fee-for-service providers and your HMO's?

What factor does benefit design and marketing and so forth play in that experience?

Mr. GRAHAM. Well, clearly you can design benefits to appeal to the people that you want to reach. If you are sophisticated in marketing, you can figure out how to get to those people. I think perhaps a better example of that was what the plan I was with did with medicare complementary. When medicare was enacted we marketed complementary coverage. We really hit it hard.

We enlisted the local independent agents. We held meetings in community centers. In a period of 60 days we enrolled 40,000 people. It astonished us. It was a good product. It was a product designed to appeal to the medicare group.

What we promised them was if it is a medicare benefit, medicare doesn't pay it all, we will pay whatever medicare doesn't pay. They found it easy to understand.

Yes, you can design these things to appeal. You can market them. On the other hand, the prospect of having an agent go through a nursing home is enough to make my hair stand on end, and an obvious impact on program cost.

This is the part of the equation that troubles me. You can establish the AAPCC objectively. It is a number that comes out of published data.

What you haven't established is what you are buying with it. What you are buying with it is two things. You are buying a list of benefits which is known, to be delivered in the form of care to a group of people, the identity and makeup of which is unknown.

That is where the crunch comes.

Senator DURENBERGER. Mr. Burdge, would you react a little bit to the subject we are on?

Mr. BURDGE. Yes. When you talk about buying benefits through a group you don't know, I think that is where the economics of the marketplace comes in. That is the responsibility of the insurer, the prepaid plan, to know whether or not they can deliver that product.

In our situation, we are a large, relatively large, provider of health care services to medicaid and medicare populations on the west coast and in Sun City.

I would say our concern about adverse selection is usually offset by our marketing efforts. We tend to overcome adverse selection by spreading the risk and by more active enrollment marketing procedures as distinct from prescreening and so forth.

So, we have found no inability to provide what we believe to be quality services to medicare and medicaid enrollees in our prepaid plans. I wouldn't anticpate any.

Senator DURENBERGER. Would you discuss with us in a little more detail, your experience with the medicaid program in southern California?

Mr. BURDGE. Well, I believe we are the largest provider of medicaid in the State of California; MediCal, rather. We have a very active program. We sell. We market that service very aggressively through a direct selling program, calling directly on MediCal eligibles. We have centers that are located conveniently to where they live.

We have several procedures. We call on them in their homes. We call them back. We tape the interview by a different person, over the phone, to make sure that they understand the program correctly, that it was represented fairly to them, and that they understand what they signed up for.

As I say, that followup call is recorded on tape and we edit the marketing procedures. We have done quite well and have an increasingly growing enrollment in that MediCal area.

Senator DURENBERGER. Thank you, gentlemen, both of you, for your testimony and for your response to questions.

[The prepared statements follow:]

STATEMENT OF THE

BLUE CROSS AND BLUE SHIELD ASSOCIATIONS

ON

MEDICARE REIMBURSEMENT FOR HMOs

for the

SUBCOMMITTEE ON HEALTH

COMMITTEE ON FINANCE

UNITED STATES SENATE

July 30, 1981

84-969 O—81——8

Mr. Chairman and members of the committee, I am Roger H. Graham, Senior Director of the Blue Cross and Blue Shield Associations which represents the 111 Blue Cross and Blue Shield Plans in the United States.

Our member Plans serve more than 100 million Americans, with 86 million persons enrolled in our private health benefit programs and another 16 million served through our roles in administering government programs such as Medicare.

I welcome the opportunity to offer our reactions to the Senate proposal to Medicare reimbursement to HMOs. Before discussing the specific issues, I would like to present some highlights about Blue Cross and Blue Shield Plans' HMO activity.

Our participation and investment in health maintenance organizations have been considerable and in many cases pioneering. Forty-six Blue Cross and Blue Shield Plans operate or provide services to 70 HMOs with 1.39 million members. Forty-three HMOs with over 850,000 members are sponsored by Blue Cross and Blue Shield Plans. Nine of these are federally qualified under Title XIII of the Public Health Service Act. Six, including three demonstration projects, are currently serving Medicare enrollees under contracts with the Health Care Financing Administration (HCFA). In addition, 27 HMOs (14 of which are federally qualified) receive services from 21 Blue Cross and Blue Shield Plans through contractual agreements. These programs enroll another 536,000 members.

Nineteen of our Plan-sponsored HMOs were the first in their markets and six were firt in their states. This does not include other pioneering HMOs which received support and services from our Plans. Our Plans have invested more than $100 million in HMO feasibility studies, development, start-up funding, and facility construction. Also, large contributions of staff resources and technical assistance have been put into HMOs by our Plans.

No other agency - public or private - has put more HMOs into operation, and we have done this while steadily reducing hospital utilization in our conventional health service benefit business.

Why are Blue Cross and Blue Shield Plans developing HMOs and other alternative delivery systems?

First, the demand for cost containment is intense and HMO programs demonstrate an ability to optimize use of hospitals. Plan sponsored HMOs have held down costly inpatient utilization to an average of 457 days per 1,000 enrollees which is equivalent to the utilization experience of all other HMOs of comparable maturity in the country.

The second reason for our development of HMOs is increased demand for them in many areas. The last decade saw the share of the health care market held by HMOs more than double. Increased interest by industry and labor in providing HMO options coupled with the mandatory dual choice provisions of the federal HMO Act have been important stimuli for HMO development. Since 1974, enrollment in Blue Cross and Blue Shield sponsored HMOs has grown 155 percent, while nationwide,

enrollment in all HMOs grew by 70 percent.

HMOs will not provide the dominant mode of health care delivery and financing in the foreseeable future, but they are valuable options, and purchasers of health care benefits are taking such programs seriously. We at the Blue Cross and Blue Shield organizations are committed to HMOs as a part of our total marketing strategy. We support legislation that will provide greater access to HMOs for all segments of the market, including Medicare and Medicaid beneficiaries.

It is our perception that relationships between HMOs and the Medicare and Medicaid programs have been severely handicapped by the difference between their fiscal philosophies. Medicare and Medicaid have employed retrospective payment of costs or charges and retained all program risk for cost and utilization. HMOs, on the other hand, employ prospective payment for many health services, and transfer much of the risk to contracting providers. This difference and this disparity between HMOs and the government programs in scope of benefits, have limited both the amount of interaction between HMOs and Medicare and Medicaid, and the mutual satisfaction with such interaction as has occurred.

Mr. Chairman, against this general background of Blue Cross and Blue Shield Plan activities in the HMO arena, I would like to focus on what I gather is one of the major questions before this Committee. How can the federal government determine appropriate reimbursement levels for HMOs under Medicare? The word appropriate in the question implies that reimbursement levels would be fair for the HMO and the federal government, and that the Medicare beneficiaries would be getting a reasonable range of care for the payment made by the federal government.

Based upon our experience with the enrollment of the elderly in general, and in HMOs in particular, I am obliged to tell you that it is extremely difficult to assure fairness in every case. The procedures suggested in the pending legislation involve the use of an "adjusted average per capita cost", 95% of which could be paid for HMO coverage. This uses available statistics to relate to regional cost variations, and creates an automatic 5% "savings" to the federal government. This seems a reasonable beginning point, and it is important that we make a beginning. However, we should understand that it is an imperfect means of assuring "fairness." There are many subtle variables which affect the real cost of providing HMO coverage. When you add the complexities of enrolling an aged population in a government funded program, we probably don't know enough to construct an adequate formula to predict those costs.

The benefit design and the HMO marketing strategy is one factor. What sort of people will they reach, and appeal to? Will the enrollees be required to change doctors, and will they perceive significantly improved benefits without proportionate cost increases? What sort of people will see these as favorable trade-offs? Part of the cost is determined by the composition of the enrollment.

Objective characteristics such as age and sex, subjective ones such as economic-cultural status, and elusive characteristics such as health status, are enrollment characteristics. They have a tremendous influence upon the cost of providing health care to the enrolled population. They cannot be predicted with certainty before enrollment, nor changed very much after enrollment. The HMO seeks to provide health care in the most cost-effective way, but it must provide the needed care. That alone establishes the cost. Fairness is a simple question of whether the payments are sufficient to cover the costs.

Actuaries make quantified judgements about the future, based upon pertinent information about the past. There is not much pertinent information about what happens when you enroll Medicare beneficiaries in an HMO on a risk basis, because very little has been done. Some of the early results are quite diverse. However, the scarcity of useful actuarial information should not stop this Committee from allowing Medicare beneficiaries to enroll under risk-based HMO arrangements. The only way we will ever gain the experience needed to be more precise is to move ahead, build in some safety factors, and keep track of what happens and why.

As useful history accumulates and is understood, much more precise actuarial work will be possible and "fairness" more readily achieved.

It is important to make a beginning. Using 95% of the "adjusted average per capita cost" as the basis for payment seems prudent and reasonable, in the absence of better data. Some HMOs may be overpaid while others are underpaid, and these should be largely offsetting. In the implementation proposals I have seen, actuarial judgement is a major factor in pricing

benefits..., what the HMO promises to provide in exchange for 95% of the AAPCC. The judgements will have to be reviewed; there will inevitably be differences of actuarial opinion; and I expect the judgement factors will be negotiated. From my long experience with government negotiations, I expect the government to be a tough negotiator. I would expect to see more HMOs come out "short" than "long". This, together with internal HMO limitations of access and capacity seem to assure that the fiscal impact on the Medicare program will not be great.

More than half a billion dollars has been invested in HMO development during the past ten years; over one-third of that by the federal government. There are now over 240 HMOs with more than 10 million members. Medicare involvement is very small and very recent. We need to affirm this country's investment in HMOs by offering enrollment to our elderly persons and proceeding to perfect ways to reimburse HMOs.

The HMO concept, and the opportunity to encourage development of these competitive models of health care delivery and financing has potential for saving a great deal of money for Medicare and the federal government in the long run. This potential, in our judgement, makes the risk of relatively small expenditures in the next few years, seem trivial by comparison.

We appreciate that some would like to limit the Federal government's exposure in this area, and find ways to proceed more slowly, for example, by conducting further demonstrations under Medicare. If the Committee concludes this approach is appropriate, we urge you to include a wide range of HMO models and sponsors. Limiting eligibility to federally qualified HMOs automatically excludes certain types and certain states from participation. For example, Minnesota is a hotbed

of HMO activity, but only one small HMO is federally qualified. HIP in New York City is a large, well established HMO which cannot comply with the technical requirements for federal qualification.

In the remainder of my remarks, I wish to address three areas of S.1509 which deal specifically with: HMO elibility, the proposed elimination of cost-based reimbursement and, under the new risk-based arrangement, the use of savings.

During the past two years of discussion, negotiations and compromise, the Blue Cross and Blue Shield Associations have repeatedly expressed concern over HMO eligibility to participate in an improved Medicare and Medicaid arrangement. In the past, participation has been essentially limited to federally qualified HMOs. We believe there are many good HMOs which are not federally qualified, for reasons having nothing to do with quality of care, financial stability, or membership satisfaction. We believe that Medicare and Medicaid beneficiaries should not be denied access to them on an arbitrary basis.

We support, Mr. Chairman, the alternative approaches to HMO elibility contained in your proposal. We support, especially, the provision which would allow state certified HMOs to enjoy the same eligibility status as federally qualified HMOs. Together with reasonable liberalization of the organizational requirements for HMO qualification in the 1981 HMO Act Amendments, your draft bill appears to provide good access. We propose some changes to strengthen it further.

To minimize the risk of HMO insolvency, we urge deletion of the requirement that HMOs retain full financial risk. This requirement is expressed in the HMO Act, and is repeated in this proposal. We have urged repeal in the 1981 HMO Amendments, and we believe that your proposal would be stronger without a full financial risk requirement.

It is prudent to permit the option of insuring services which they can not prepay to providers, in effect prepaying them instead to carriers. An HMO which is fully prepaid is unlikely to be surprised by insolvency, or to jeopardize the security of its members. This should be particularly important to the federal and state governments as they contemplate the payment of advance premiums to an HMO for the care of Medicare and Medicaid beneficiaries.

The second area where we would like to see a change, Mr. Chairman, is the proposed elimination of cost-based reimbursement to HMOs. Of the current 51 Medicare/HMO contracts including one risk-based and 7 demonstration projects, 43 of the contracts are for cost-based reimbursement as currently provided for under Section 1876 of the Social Security Act. The elimination of the option to receive cost-based reimbursement would require those HMOs to accept risk-based payments or if this were not possible, to be reimbursed only as conventional fee for service Part B providers.

Not every HMO will be able to participate under the new risk-based arrangment. HMOs whose costs exceed the adjusted average per capita cost (AAPCC) in their areas could not reasonably participate. We feel strongly that in order to ensure the greatest access of Medicare eligibles to HMO services, that HMOs should be allowed to select the most appropriate payment arrangement and that the elimination of the option for cost-based reimbursement will have the practical effect of limiting access.

The third and last area I wish to address is the use of savings under the new risk-based arrangement. We are pleased that these savings can be used by the HMO to provide additional benefits or services, reduce the premium, buy-out the Medicare copayments and deductibles and/or provide rebates or dividends to enrollees. However, in the event that the HMO decides to provide additional benefits, the draft legislation requires that the benefits be selected by a group of enrolled Medicare individuals from alternatives presented by the HMO.

HMOs, whether financially qualified or lines of business of other corporations, are governed by boards which almost without exception have substantial consumer representation. We feel that the selection of benefits to be provided should be left to the HMOs' governing bodies and that the aforementioned provision imposes an additional complication to HMO operation without the accompaniment of commensurate value to Medicare enrollees.

We also have some other more technical comments on the bill. These are points which we believe need clarification or mofication to both protect beneficiaries and recognize the way competitive model plans do business. We would be happy to work with staff on these technical issues.

Thank you, Mr. Chairman, for the opportunity to express our views.

SUMMARY OF STATEMENT BY RICHARD M. BURDGE,
SENIOR EXECUTIVE VICE PRESIDENT
OF THE INA CORPORATION AND
PRESIDENT OF THE LIFE AND HEALTH GROUP,
BEFORE THE SUBCOMMITTEE ON HEALTH
OF THE SENATE COMMITTEE ON FINANCE

July 30, 1981

Witness:

Richard M. Burdge, Senior Executive Vice President of the INA Corporation and President of the Life and Health Group.

Summary of Statement

INA remains committed to four basic principles to improve the nation's health care system. Under these principles, federal health care programs should:

-- encourage alternative health care plans to meet the needs of Medicare beneficiaries;

-- replace the federal government's retroactive cost reimbursement system with fixed premium financing, thereby creating incentives for insurers, providers and consumers to control costs and to utilize health care resources efficiently;

-- encourage consumer participation, cost-sharing and informed choice; and

-- improve the accessibility and quality of health care provided to America's senior citizens by rechannelling resources saved through these improvements into expanded coverage, benefits and services for the elderly.

We believe the following specific provisions should be included in any new Medicare program in order to achieve these principles:

-- Congress should create a new program under Medicare that would enable qualified alternative health benefit plans, including state and federally qualified HMOs, insurance carriers offering indemnity or service benefit plans, and other qualified health services organizations, to compete for the federal Medicare dollar;

-- Legislation should include a statement of policies and objectives that the program be administered

to foster competition, encourage cost-efficiency, ensure informed consumer choice and enhance the quality of consumer responsive health care services;

-- Congress should replace cost reimbursement with fixed rate premium financing;

-- The statutory formula for determining the government's per capita contribution to each plan should reflect competitive pricing in the marketplace, along the lines of the methodology used in the Federal Employee Health Benefits Program;

-- The government's contribution to total premium cost should be established at a level that encourages consumers to select the most efficient plan without increasing the current aggregate out-of-pocket costs paid by Medicare beneficiaries;

-- Participating health plans should have the flexibility to use an experience-based rate setting system;

-- Guaranteed basic benefits comparable to Medicare Parts A and B should be mandated by statute, but plans should have the freedom to offer additional benefits as options;

-- Health plans should be free to apply the difference between premium revenues and costs to expanded benefits, additional services, investment in capital and human resource improvements, rebates on premiums, or retention of profits;

-- Health plans should be encouraged to design coinsurance, co-payments, and deductible provisions that encourage efficient utilization with emphasis on first dollar cost-sharing;

-- Health plans should not be encumbered with restrictive government regulations and conditions that are not essential to the achievement of the policy objectives and HMOs and other plans should be exempted from various certificate of need and other present regulatory requirements.

By enacting Medicare legislation with these provisions, the federal government will become a leader in demonstrating how marketplace economics promotes efficiency, how the consumer can make responsible choices, and how healthy competition will improve access to quality health care at a reasonable cost.

STATEMENT BY RICHARD M. BURDGE,
SENIOR EXECUTIVE VICE PRESIDENT
OF THE INA CORPORATION AND
PRESIDENT OF THE LIFE AND HEALTH GROUP,
BEFORE THE SUBCOMMITTEE ON HEALTH
OF THE SENATE COMMITTEE ON FINANCE

July 30, 1981

Mr. Chairman and Members of the Subcommittee:

My name is Richard M. Burdge. I am Senior Executive Vice President of the INA Corporation and President of the Life and Health Group. INA is one of the nation's largest diversified financial services companies and oldest commercial organizations. INA's history goes back to 1792 with the formation of its principal subsidiary and the nation's first stock insurance company, Insurance Company of North America. Among its health-related activities, the INA Healthplan, Inc. is the largest investor-owned operator of prepaid health plans in America.

Since its entry into this field in 1978, INA's operations have grown to include nine HMO plans in five states with a total enrollment of more than 450,000 patients (two plans in California, two in Arizona, three in Florida, one in Washington and one in Texas). Eighty percent of our enrollment consists of commercial members, drawn from

employee groups. The remaining twenty percent is composed of some 30,000 Medicare enrollees and 60,000 Medicaid beneficiaries. The Medicaid patients are all from INA Healthplan of California which has had a Medicaid contract with the State of California for the past nine years.

INA is committed to continued growth in this area in order to maximize the benefits of employer-based health plans through the encouragement of competition, incentives to control costs and comprehensive care options for employees.

HMOs have demonstrated great potential in containing costs and providing consumer-responsive services. And because of their emphasis on competition and preventive medicine, HMOs, in our view, hold great promise for meeting the needs and solving the problems of our nation's health care system, especially for older Americans. As Secretary Schweiker recently remarked before the National Journal Conference on Health, competition and prevention are the cornerstones of the Reagan Administration's health care policy. Likewise, INA's commitment to the HMO concept is the cornerstone of our program to provide innovative solutions to our nation's health care problems and is entirely consistent with the Administration's health care philosophy.

I thank you for the opportunity to testify before this subcommittee on how the principles of market-oriented economics can be applied to the Medicare program to improve the quality and cost-effectiveness of health care for the elderly. I would be remiss, however, if I first did not commend the Chairman of this subcommittee, Senator Durenburger, and Senator Heinz, the author of S. 1509, the Competitive Health and Medical Plan Act, for their longstanding efforts to apply these principles to the nation's health care system. Through these efforts, Congress is beginning to recognize the urgent need to create incentives to control escalating costs and to improve the delivery of quality health care to the nation, and especially its senior citizens.

I now would like to explain INA's position on improving the country's health care system and set forth the principles upon which we believe any health care legislation should be based. I also will discuss specific provisions that we believe are essential to a successful legislative solution to the problems in our Medicare system.

Principles for an Improved System

INA remains committed to four basic principles to improve the nation's health care system, which we first

outlined in our testimony before the full Senate Finance Committee on March 28, 1979. To illustrate how these principles can be applied in federal health care financing programs, INA developed a model that we call the Health Care Options Plan Entitlement, or HOPE.* Under HOPE, Medicare and Medicaid beneficiaries could choose from among alternative health benefit plans, including HMOs, which would be reimbursed on a competitively priced, fixed premium basis. Under the principles applied in HOPE, federal health care programs should:

-- encourage alternative health care plans to meet the needs of Medicare beneficiaries;

-- replace the federal government's retroactive cost reimbursement system with fixed premium financing, thereby creating incentives for insurers, providers and consumers to control costs and to utilize health care resources efficiently;

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* The HOPE proposal and an analysis of its cost implications are set forth in a white paper entitled "Financing Federal Health Care Programs Through the Application of Market-Oriented Economics," April, 1980.

-- encourage consumer participation, cost-sharing and informed choice; and

-- improve the accessibility and quality of health care provided to America's senior citizens by rechannelling resources saved through these improvements into expanded coverage, benefits and services for the elderly.

Let me state specifically how these four principles should be advanced in legislative programs. Our analysis is based on a review of S. 1509 and other proposed health care bills relating to Medicare.

Encouragement of Alternative Plans

First, the Medicare program should be opened up to encourage the participation of HMOs and private insurers in providing comprehensive health benefit plans to older Americans. Broadening Medicare participation to include alternative health care plans will promote greater efficiency in the utilization of hospital facilities and medical services and encourage consumer-responsiveness in the delivery of health care services.

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State-licensed as well as federally-qualified HMOs should be encouraged to participate in the Medicare program and to compete for the federal Medicare dollar. In addition, insurance carriers should be allowed to offer indemnity plans or service benefit plans to the Medicare population on a nationwide basis. These plans currently provide coverage to the vast majority of health care consumers. Full participation by these experienced companies would enhance greatly the goal of providing the Medicare consumer a range of alternative benefit plans.

The benefits of broad participation in health care programs were recognized by Senator Durenburger in the bill he introduced in the last Congress: the Health Care Incentives Reform Act of 1979 (S. 1968, formerly introduced as S. 1485). Under Section 86(b)(1) of S. 1968, a "health benefit plan" would qualify if it provided the specified hospital or medical services "through prepayment of fees, direct provision of services, payments of insurance premiums, or reimbursement for expenses incurred." And an organization offering such a plan could participate if it was "lawfully engaged in providing, paying for, or reimbursing the cost of, health services under group insurance policies or contracts, medical or hospital service agreements,

membership or subscription contracts, or similar arrangements." S. 1968, § 86(b)(2)(A). Thus, Senator Durenburger's bill would have permitted participation by insurance carriers offering indemnity plans, service benefit plans and other types of plans on a nationwide basis. We believe that a similar provision should be incorporated in any Medicare bill to promote such participation by insurance carriers as well as HMOs and other prepaid plans.

While it is important to provide a wide range of alternative plans, we also recognize the need to prevent abuses and to ensure that participating plans are truly qualified. Congress should require the Secretary to establish qualification standards that are consistent with the overall objective of competition and broadened participation. Unnecessary restrictions on entry should be avoided, but minimum qualifications, based on such factors as minimum total enrollment, minimum level of non-Medicare enrollees, minimum experience requirement, or some combination of all three, would be appropriate.

Eligibility requirements should be administered equitably among all types of competing plans, unlike the

current system in which HMOs are subject to special requirements and less advantageous financing terms. Indeed, federal financing among the competing plans should be equitable; no particular type of plan should be given unfair leverage or a competitive edge.

Finally, consumer information provisions should ensure that beneficiaries are informed about alternative plans and able to make an intelligent choice among them. The government should facilitate the dissemination of clear, concise and easily comparable information about competing plans.

Federal Financing Changes

A second fundamental principle applicable to any new Medicare program is the encouragement of cost-conscious behavior by insurers, providers, and beneficiaries in the utilization of health care services. Instead of paying for health care services on a cost reimbursement basis, the federal government should purchase health care coverage by paying fixed premiums prospectively. Moreover, these payments should reflect competitive pricing in the marketplace.

Perhaps the best working example of a successful plan predicated on competitive fixed premium pricing is the Federal Employees Health Benefits Program (FEHBP), which has been in effect since 1960 and is now providing health care services to over ten million individuals. More than eighty different health care plans, including HMOs, participate in this program, offering federal employees a wide range of choices among competing health delivery systems. Whichever plan the employee chooses, the government, as employer, contributes a fixed amount, calculated as sixty percent of the average of the premiums of several of the largest plans. The employee pays the rest. Because the amount of the government's contribution does not vary with the cost of the plan selected, employees are encouraged to select that plan which provides the greatest benefits at the lowest cost. The plans, in turn, are forced to compete for the employee's premium dollars by reducing administrative costs and providing efficient health care services or contracting with the most efficient providers.

S. 1509 and other proposed bills have employed a different reimbursement mechanism whereby the government payment received by health plans is calculated as a percentage of the adjusted average per capita cost (AAPCC).

The AAPCC is the average per capita amount paid under the traditional Medicare system for medical services furnished under Parts A and B of Medicare. We believe, however, that there are several reasons that make a competitive pricing mechanism superior to the AAPCC method:

-- The AAPCC mechanism builds the inflated costs of the present, flawed retroactive reimbursement system into the actuarial base. As more and more people join the competitive alternative, the base of the traditional system becomes smaller and the AAPCC increasingly inflated. It simply is not sound public policy to legislate a formula that most experts agree will exacerbate the increase in federal health care expenditures as more persons opt out of the traditional system.

-- A payment based on the AAPCC does not reflect truly competitive pricing behavior in the marketplace and thus diminishes the incentive to control costs and price competitively. Such payments may be substantially higher than necessary, creating windfall profits and encouraging excessive spending on marketing or capital investment.

-- The formula imposes an additional overhead burden in calculating costs both for the government and the participating health plans.

In contrast, under the mechanisms used in the FEHBP or proposed in our HOPE model, the Secretary of Health and Human Services, through the Health Care Financing Administration, would establish a monthly fixed dollar federal per capita payment toward the premium cost of each plan. The federal payment would equal a fixed percentage, e.g., eighty percent, of an average of certain subscription (premium) charges in effect or proposed at the beginning of each calendar year. The average would be calculated by identifying the plans that offer, at a minimum, the benefits provided for in Parts A and B of Medicare and that serve the largest number of enrollees in each of the following categories:

(a) an indemnity plan;

(b) a service benefit plan; and

(c) two comprehensive prepaid medical plans.

The government would pay a fixed percentage of the average premium, and the Medicare beneficiary would

pay the remainder of the premium cost of the plan of his choice in lieu of the contribution now made under Medicare Part B.

We believe that a federal per capita payment equal to eighty percent of the average premium cost, rather than one permanently based on the AAPCC, would encourage cost-consciousness by consumers, providers and insurers. Because beneficiaries would pay the additional premium costs, they would have an incentive to select a plan that provides the best coverage for the lowest cost. In addition, co-payments and deductibles would encourage efficient utilization of services. The precise design of cost-sharing, however, should be left to the marketplace to determine, although basic parameters could be established (e.g., both a ceiling and a floor on the amount of total cost-sharing allowed could be provided).

Another component of S. 1509 and other proposed Medicare bills is the inclusion of a requirement that if the Medicare reimbursement exceeds the adjusted community rate (ACR), the difference must be applied to additional benefits, decreased deductibles, or rebates. These proposals mandate the creation of a panel of Medicare beneficiaries to decide how these funds should be applied. We believe

that establishment of an ACR evaluation mechanism would increase the administrative cost and needlessly embroil both the government and participating plans in difficult questions regarding the definition and computation of "profits." This process could create the potential for a politicized adversarial relationship that is unnecessary if market forces are relied upon to determine the price and allocation of benefits.

A community rating mechanism further precludes the HMO from using reimbursement financing to increase the number of physicians, to improve existing services, to purchase new equipment and facilities, to expand the health plan's market area, or to provide a return to the health plan for the risk associated with servicing the Medicare population. In short, the ACR test would frustrate growth and expansion of HMOs.

Consumer Participation

The third fundamental principle is that of informed consumer choice and participation. Meaningful consumer participation means that real alternatives are provided to each Medicare beneficiary. Consumers should be able

to determine what price to pay for health care coverage, what additional benefits and services to include, whether to buy comprehensive, single-stop service or retain the flexibility to select the best possible specialist, and what emphasis to place on convenience, ambience, efficiency, reputation, and quality of service. Beneficiaries dissatisfied with service or cost should be free to select a different plan during an open season established each year for this purpose. This annual "open season" approach has been very effective under the FEHBP. It maximizes the opportunity for informed consumer choice based on comparative information while discouraging excessive marketing or destructive competition, an unfortunate by-product of early HMO development in certain sections of the country. It further ensures continuity of health care service without creating substantial overhead costs.

Participating plans should be authorized, however, to take reasonable steps to minimize adverse selection. For example, a seriously ill person could change to a higher benefit option during the open season. Adverse selection could be discouraged by imposing a delay of six months between the open enrollment period and the effective date of the plan change. Alternatively, treatment of pre-existing

conditions could be subject to the terms of the old plan for a period of a year after the change. Other less desirable approaches include less frequent "open seasons" and surcharges for persons making higher benefit changes.

Fundamental to the application of market-oriented economics in the health care sector is meaningful financial participation by the consumer. For Medicare beneficiaries, this feature means cost-sharing to the extent they are able to afford it and, more importantly, at a time when such cost-sharing will be a factor in making critical choices. Under the present law, Medicare beneficiaries bear a heavy cost-sharing burden only after substantial medical expenses have been incurred or hospital days accumulated. This approach destroys any incentive for consumers to choose wisely as well as for providers to control costs. Rather, consumers should share the financial burden at a time when they are capable of exercising an intelligent choice and not after the critical decisions about insurers, plans, hospitals, or doctors already have been made and their financial resources are depleted. The purpose of cost-sharing is to foster efficiency and to ensure that adequate standards of care are provided at a reasonable and affordable cost, not to push those persons *in extremis* into financial and spiritual bankruptcy.

We thus would prefer to see the cost-sharing burden under Medicare shifted forward. Health plans should be encouraged to require beneficiaries to contribute to the cost of premiums (by paying the difference between the federal capitation payment and the competitively priced plan) and authorized to charge certain deductibles and first dollar co-payments for services provided, including a daily co-payment for hospitalization instead of ceilings on the number of hospital days or increased cost-sharing as days are accumulated, as provided under current law.

While the exact form of such cost-sharing should be left to the marketplace, Medicare beneficiaries could be required to pay some minimum share of the cost of their health care, including a portion of the first dollar charges for hospital and medical services. Such a requirement could be combined with a ceiling on total co-payments or catastrophic coverage.

Other provisions should ensure that beneficiaries are adequately informed about their plan and alternative plans and that they have the right to a hearing before the Secretary and to judicial review of certain disputes.

Improved Access and Benefits

The fourth principle enumerated above would encourage improved access and health care services for all older Americans. A basic floor of acceptable benefits should be established by requiring plans to provide, at a minimum, the services now mandated under Medicare Parts A and B for persons entitled to benefits under those parts, and the services provided under Part B for individuals entitled to benefits under that part only. However, there should be no ceiling imposed on the additional benefits that various plans may wish to offer in response to consumer demand. The most efficient plans would be able to offer supplementary benefits with little or no additional premium cost. As long as the minimum required benefits are provided, plans should be free to respond to consumer demand by lowering premiums or expanding benefits, or, alternatively, retaining profits.

Elements for a Successful Medicare Program

At this point, it may be helpful to summarize the specific provisions that we believe should be included in any new Medicare program in order to achieve the objectives noted above.

-- Congress should create a new program under Medicare that would enable qualified alternative health benefit plans, including state and federally qualified HMO's, insurance carriers offering indemnity or service benefit plans, and other qualified health services organizations, to compete for the federal Medicare dollar;

-- Legislation should include a statement of policies and objectives that the program be administered to foster competition, encourage cost-efficiency, ensure informed consumer choice and enhance the quality of consumer responsive health care services;

-- Congress should replace cost reimbursement with fixed rate premium financing;

-- The statutory formula for determining the government's per capita contribution to each plan should reflect competitive pricing in the marketplace, along the lines of the methodology used in the Federal Employee Health Benefits Program;

-- The government's contribution to total premium cost should be established at a level that encourages

consumers to select the most efficient plan without increasing the current aggregate out-of-pocket costs paid by Medicare beneficiaries;

-- Participating health plans should have the flexibility to use an experience-based rate setting system;

-- Guaranteed basic benefits comparable to Medicare Parts A and B should be mandated by statute, but plans should have the freedom to offer additional benefits as options;

-- Health plans should be free to apply the difference between premium revenues and costs to expanded benefits, additional services, investment in capital and human resource improvements, rebates on premiums, or retention of profits;

-- Health plans should be encouraged to design coinsurance, co-payments, and deductible provisions that encourage efficient utilization with emphasis on first dollar cost-sharing;

-- Health plans should not be encumbered with restrictive government regulations and conditions that are not essential to the achievement of the policy objectives and HMOs and other plans should be exempted from various certificate of need and other present regulatory requirements.

Conclusion

When Congress enacted Medicare, it strongly intended that Medicare beneficiaries not be treated as second class citizens, but that they receive the same health care service that is available to private paying patients. However, the experience under the current Medicare system has blurred that objective. Today, many Medicare beneficiaries are poorly treated and denied the right to participate in health plans or to receive the services of their choice. They further must bear the burden of catastrophic illness. In sum, they have been relegated to the bottom of a two-tiered health system.

Under the Medicare program described above, Medicare beneficiaries would truly become first class health care citizens. Like private paying patients, Medicare beneficiaries could choose among alternative health plans and delivery

systems. Like private paying patients, Medicare beneficiaries could change their minds and express their dissatisfaction with a certain plan by choosing an alternative. And like private payers, beneficiaries would share in the costs at a time they are able to afford it.

While the above discussion has focused on only a limited segment of the nation's population -- the elderly -- the underlying principles of competition, reimbursement reform, consumer participation, and guaranteed benefits have broader applicability for the nation's health care system. We would encourage your continued interest in expanding these principles to cover the entire national health care market, including the Medicaid program in particular.

By aligning all federally financed health care programs with these principles, the federal government will no longer distort the incentive system in the health care marketplace, encourage over-utilization and inefficiency, or penalize innovation and cost-consciousness. Rather, the federal government will become a leader in demonstrating how marketplace economics promotes efficiency, how the consumer can make responsible choices, and how healthy competition will improve access to quality health care at a reasonable cost.

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Senator DURENBERGER. Our next panel will be Mr. James Lane, vice president and counsel, Kaiser Foundation Health Plan, Inc., Oakland, Calif., on behalf of Group Health Associations of America and Mr. Gerald Coe, counsel, Group Health Cooperative of Puget Sound, Seattle, Wash., on behalf of Group Health Associations of America.

STATEMENTS OF JAMES LANE, VICE PRESIDENT AND COUNSEL, KAISER FOUNDATION HEALTH PLAN, INC., OAKLAND, CALIF., ON BEHALF OF GROUP HEALTH ASSOCIATIONS OF AMERICA, AND GERALD COE, COUNSEL, GROUP HEALTH COOPERATIVE OF PUGET SOUND, SEATTLE, WASH., ON BEHALF OF GROUP HEALTH ASSOCIATIONS OF AMERICA

Mr. LANE. My name is Jim Lane. I am accompanied by Gerald Coe, who is general counsel, for Group Health Cooperative of Puget Sound, the only HMO with a risk-based medicare contract under present law.

Mr. Coe has a statement which he will submit for the record. I will be the only one to present testimony here.

When the medicare program was enacted in 1965, there were only about 10 or 12 prepaid group practice plans in the country and little consideration was given to contracting with them on a prepaid basis in a manner consistent with their financial structure.

Today there are over 240 HMO's serving nearly 10 million members.

The competitive impact of HMO's on the markets in which they operate has been repeatedly demonstrated. Through a comprehensive, coordinated system of health care delivery, HMO's create incentives for the appropriate and efficient use of services, while at the same time, improving access to care.

By providing an alternative to the fee-for-service system, HMO's inject an element of competition into the marketplace which can alter the patterns of service delivery by other providers.

When the medicare program was enacted it held out to older Americans the promise of access to adequate, affordable health care.

Unfortunately, for too many beneficiaries, this promise has gone unfulfilled. Since 1965 inflation in medical costs has led to high out-of-pocket costs for medicare beneficiaries which you know well.

Restrictions on coverage and difficulties in convincing physicians to accept assignments have resulted in the failure of the program to deliver services at a cost and in a manner which Congress originally intended.

Health maintenance organizations can offer the elderly a measure of relief from some of these administrative and financial burdens, and, at the same time, can offer the Federal Government a more efficient utilization of its medicare dollars.

Through an HMO, as you have learned through the demonstration projects, the medicare beneficiary not only receives comprehensive service from a single source, including preventive care and any speciality care he or she might need, but also has the security of knowing that these services will be provided at a predictable prepayment.

Since most older Americans live on fixed incomes, the certainty of a cap on health care costs is even more important to medicare beneficiaries than to active wage earners. Only 1.5 percent of medicare beneficiaries or 350,000 out of 25 million receive their health care through HMO's. Of 200 operating HMO's, only 47 have become medicare providers and the main reason for their doing so has been to continue service to current enrollees after they have obtained age 65. Kaiser Foundation health plans have over 200,000 medicare enrollees at this time.

The problem with current medicare reimbursement options for HMO's is that cost based reimbursement mechanisms impose upon them retrospective cost finding based upon the delivery of specific services. This methodology is not consistent with the HMO's method of providing for a prospectively determined premium in its budgeting and ratemaking process. In addition, the medicare beneficiary receives no benefits from savings generated by HMO efficiencies. The risk based reimbursement mechanism under section 1876, which is the medicare payment provision in the current law, does place the HMO at risk, but final payment remains retrospective and is sometimes delayed 2 or 3 years following the provision of services.

This mechanism does provide for a sharing of savings of up to 20 percent between the HMO and the Government. These are savings which result from the difference between the HMO's cost for services and the AAPCC which you heard discussed today. Any further savings are returned to the Federal Government. While the HMO receives some of the benefits of its efficiencies, current law does not require that the savings be used for the benefit of the HMO's members as it properly should be. It is little wonder that under this section only one HMO, Puget Sound, has signed a risk contract.

Another serious drawback of the present law has been the requirement that all medicare members, including those enrolled at the time the plan enters into a risk contract must be, as we say, locked in. This imposes a significant hardship on those members who have for many years, sometimes over 15 years, been accustomed to a different way of handling it. There is a need for a provision which would allow a reasonable transition and not place this requirement upon existing members.

S. 1509 is a substantial improvement over present law. With a few modifications, we believe the measure will create a workable mechanism to increase the availability of HMO membership to medicare beneficiaries.

The bill provides an HMO with a prospective fixed payment which places the plan at risk in the same manner it accepts risks for the provision of care to its own medicare members. All reimbursement, in excess of the ACR must be returned to the medicare members. It is the beneficiary who gains through the savings which are generated.

I think that is a very important point.

The bill provides that medicare beneficiaries who are members of the HMO at the time it enters into the risk basis contract will be able to elect to continue to receive their care on a cost basis.

This provision recognizes that it is difficult for the elderly who may have established patterns of seeking care outside of the plan, a practice not allowed under the risk basis arrangement to change their mode of receiving health care. We also support the open enrollment provision in S. 1509. HMO's will be required to enroll medicare members during open enrollment periods designed to make the plan readily available to a cross section of the eligible medicare population in the community.

I will finish my statement with one comment. You asked a question about marketing. We believe it is very important that an organized method of marketing be built into the social security system. We propose serious consideration be given to notifying all new medicare beneficiaries, say when they are 64½, as they approach the age of retirement, that there are options available to them, to provide them with the options and give them the choice at that time. Then you can build a system much like we have in the employment area where as new hires come to work, they are given choices, and people will then make that choice at a time when they are changing and that can be done automatically.

At the present time the major marketing mechanism outside of advertisement is for HCFA to send people a little post card which doesn't work very well. We had to cancel the post card because we couldn't agree on terms with them. It is clear that it does not work very well.

Thank you very much for this opportunity.

Senator DURENBERGER. I heard what you said. I am going to ask somebody sooner or later what they—whether they have an opinion about continuing to fund medicare off the payroll tax and what that does to people's attitudes about medicare too.

First, I want to announce that the father of S. 1509 is also trying to be the father of an amendment to the Clean Air Act. So, John Heinz probably won't make it here today, as he wanted to. He regrets very much not being here.

Second, to both of you, both of your statements will be made a part of the record.

Will you share with us your views on the issue of including health status in the AAPCC?

Mr. LANE. Well, I would like to make a general statement about the AAPCC. The one used in the demonstrations is in current law. It is the provision that was adopted in 1972.

We think we learned a lot during the demonstration process, about whether that is adequate. We think a health status adjustment would improve the situation.

We have a fairly elaborate program to find out from all the new members what some of their health status indicators were. We did it in a way that didn't indicate to them that it was relevant at all to their enrollment.

That is, they were enrolled. They were sent a questionnaire and asked to respond to it based on the use of the response in providing medical care for them which it is also useful for.

As Roger Graham indicated, you could probably build a health status system that would be very elaborate and very difficult to run. Hopefully, you can build one that isn't that elaborate and difficult to run, although there will be costs associated with it.

I think it is very important to emphasize that HMO's want as accurate an AAPCC as possible. I don't think there is any desire on HMO's to have one that is too high. There is certainly no desire to have one that is too low. So, it is very important for us to have one. The real question is: How can we find out about how to develop that. It is also important, if you are going to move toward competition in the rest of the medicare system, because you face precisely the same issue.

We think that the law should be changed. We should move forward. HMO's are not going to rush to sign contracts even under this law. They are by nature fiscally conservative. This is a hard group to market to. It is an unknown group. If you have primary physicians who are used to taking care of young families and you start talking about taking care of older persons that is a change in practice. So, I don't think you should be worried about HMO's rushing in and, as some people say, "Ripping off the Federal Government."

Senator DURENBERGER. You mentioned in your testimony that all excess reimbursement should be returned to the medicare members, but you—I believe you objected to the option in S. 1509 that cash rebates be one of those ways.

Would you explain why you object to the cash rebate?

Mr. LANE. Well, we really didn't object to them totally. I believe we said that they should be looked at carefully.

There are cases in which rebates may be important and I would like to give you two examples. One is in the medicaid and medicare crossover situation. In California, the medicaid program is so comprehensive that it is very difficult to give its beneficiaries a benefit incentive to join the program. In that case, a cash incentive might be appropriate. Those are persons who are dual covered.

Under the bill, if you read it literally, you have to give the savings to the member and it is very difficult to do that. The option, of course, is to give it to the State of California or to give it back to the Federal Government. The law provides that it can be given back to the Federal Government.

In the second case, there are groups which pay 100 percent of the premiums for comprehensive supplemental coverage for medicare beneficiaries. There, once again, you have the same problem and the cash payment might be appropriate. I think there is some concern about generalizing that principle and getting people into situations where they have to make tradeoffs between comprehensive benefits and cash. I think that is what we need to be concerned about that they not be required to make those tradeoffs.

Senator DURENBERGER. Mr. Coe, let me ask you about your experiences under the risk contract that you have here. I guess you are the only organization operating under a risk contract under the present medicare reimbursement system.

It also appears you have been able to achieve some savings under the contract which you have shared with the Federal Government.

So, but in spite of your ability to make a risk contract work under the present system, your testimony seems to indicate you support changing the system.

So, would you highlight for us your experience under the risk contract and why certain of these changes are necessary?

Mr. Coe. I think that most of our experience relates to prospective reimbursement versus retrospective reimbursement. Retrospective reimbursement, in our particular case means that in passing the savings sharing along to the member, it is very difficult, if not impossible, to budget in a given year for something when you won't know the exact amount until 2 or 3 years down the road. It is not consistent with the HMO's normal way of doing business which is on a prospective basis. You set a rate; you take your risks that is what we would prefer to do with our medicare populations just as we do with every one of our groups. I think that prospectivity is the most significant change in the law and is the one we support the most.

We also support the inclusion of a health status factor in the AAPCC calculation. I think our biggest concern is whether you can develop a valid factor, a valid yardstick by which you can measure health status. Assuming that you can, it is going to be to the HMO's benefit just as much as to the Government's benefit. The Government's benefit is in its ability to predict the health status of the members that are enrolling in the HMO and to provide a reimbursement level which is not excessive. In turn, the HMO will have some level of assurance that the if it experiences adverse selection it will be adequately reimbursed. I think a valid health status factor will address both of those concerns. To that extent, it is an important factor to include in the law and we support it.

Senator Durenberger. Thank you both very much for your testimony. Your written testimony and your response to questions today.

Thank you.

Mr. Lane. Thank you, Senator.

Mr. Coe. Thank you.

Senator Durenberger. Thank you both.

[The prepared statements follow:]

STATEMENT
ON BEHALF OF
GROUP HEALTH ASSOCIATION OF AMERICA, INC.

JAMES LANE
VICE PRESIDENT AND COUNSEL
KAISER FOUNDATION HEALTH PLAN, INC.

AND

GERALD COE
ACTING CHIEF EXECUTIVE OFFICER
GROUP HEALTH COOPERATIVE OF PUGET SOUND

BEFORE THE
SUBCOMMITTEE ON HEALTH
COMMITTEE ON FINANCE
UNITED STATES SENATE

ON
MEDICARE REIMBURSEMENT FOR
HEALTH MAINTENANCE ORGANIZATIONS

JULY 30, 1981
WASHINGTON, D.C.

SUMMARY

- The establishment of the HMO industry as an effective competitive element in the health care marketplace argues for development of an HMO Medicare reimbursement mechanism which increases the availability HMO membership to Medicare beneficiaries.

- Present methods of reimbursement of HMOs under Medicare are inconsistent with the budgeting and ratemaking process of HMOs and do not give Medicare beneficiaries the full benefits of HMO membership.

- S. 1509 and similar proposals which provide for prospective risk-based reimbursement of HMOs by Medicare and the use of savings generated by HMO efficiencies for the benefit of their Medicare members successfully address the majority of the problems of current law and will expand the opportunities for Medicare beneficiaries to join HMOs.

Mr. Chairman and Members of the Subcommittee, I am James Lane, Vice President and Counsel, Kaiser Foundation Health Plan, Inc. and I am presenting testimony on behalf of the Group Health Association of America. GHAA represents a majority of the group and staff model health maintenance organizations in the nation, over 100 plans, and our members serve approximately 8 million enrollees, 80% of the total national HMO enrollment.

I am accompanied by Gerald Coe, Acting Chief Executive Officer for Group Health Cooperative of Puget Sound, the only HMO with a risk-based Medicare contract under present law. Mr. Coe would like to submit a statement for the record.

When the Medicare program was enacted in 1965, the entire HMO industry consisted of only 10-12 plans, and little consideration was given to contracting with them on a prepaid basis in a manner consistent with their fiscal structure.

Today, there are over 240 HMOs serving nearly 10 million members nationwide. The competitive impact of HMOs on the markets in which they operate has been repeatedly demonstrated. Through a comprehensive, coordinated system of health care delivery, HMOs create incentives for the appropriate and efficient use of services while at the same time improving access to care. The impact of these internal incentives is most dramatically evidenced in the rate of hospital utilization of HMOs which is one-third to one-half lower than comparable fee-for-service utilization. The savings so generated are translated into benefits for our members, thus HMOs can usually provide a much broader range

of services to their enrollees than is found in standard indemnity plans. By providing an alternative to the fee-for-service system, HMOs inject an element of competition into the marketplace which can alter the patterns of service delivery by other providers.

With the growth of the HMO industry and its establishment as an accepted and important part of the health care delivery system, the time has come to develop a method of Medicare reimbursement which takes advantage of all of the incentives and benefits of an HMO.

When the Medicare program was enacted, it held out to older Americans the promise of access to adequate, affordable health care. Unfortunately, for too many beneficiaries, this promise has gone unfulfilled. Since 1965, inflation in medical costs has led to excessive out-of-pocket payments, added expenses. Restrictions on coverage and difficulties in convincing physicians to accept assignment have resulted in a failure of the program to deliver services at a cost and in a manner which Congress originally intended.

Health maintenance organizations can offer the elderly a measure of relief from some of these administrative and financial burdens and at the same time can offer the federal government a more efficient utilization of its Medicare dollar.

Through an HMO, the Medicare beneficiary not only receives comprehensive services from a single source, including preventive care and any specialty care he or she might need, but also has the security of knowing that these services will be provided at a predictable prepayment. Since most older Americans live on fixed incomes, the certainty of a cap on health care costs is even more important to Medicare beneficiaries than to active wage earners.

There have been a number of reasons for low HMO Medicare enrollment to date including restrictive state laws and the opposition of established medical institutions which have inhibited HMO growth. However, the chief reason has been the Medicare reimbursement options available to HMOs.

Thus, only 1.5 percent of Medicare beneficiaries, or 350,000 out of 25 million, receive their health care through HMOs. Of 200 operating HMOs, only 47 have become Medicare providers, and the main reason for their doing so has been to continue service to current enrollees after they have attained age 65.

The problem with current Medicare reimbursement options for HMOs is that cost-based per capita reimbursement mechanisms under section 1833 and section 1876 both impose upon HMOs retrospective cost finding based upon the delivery of specific services. This methodology is suited to the fee-for-service system not the HMO's method of providing care for a prospectively determined premium and its budgeting and ratemaking process. The Medicare beneficiary receives no benefit from savings generated by HMO efficiencies.

Risk-based reimbursement under section 1876 does place the HMO at risk but final payment remains retrospective and is sometimes delayed two or three years following the provision of services. The reimbursement mechanism does provide that the HMO and HHS share equally in the first 20 percent of the savings resulting from the difference between the HMO's cost for service to its Medicare members and the comparable cost for delivery of services to those members in the fee-for-service sector in the area in which the HMO is located. Any further savings are returned to the federal government. While the HMO receives some of the benefit of its efficiencies, current law does not require that this benefit be used for the benefit

of the HMO's Medicare members as it properly should be.

A third problem with current law and a provision which is as much at odds with the HMO's method of operation as the long-delayed payment, is the requirement that the HMO offer a benefit package limited to Medicare mandated services. Such a package excludes preventive and health maintenance services which are an integral part of the HMO's comprehensive health care system, and a major advantage which the HMO offers its enrollees. HMOs should be permitted to offer comprehensive benefit packages to their Medicare members.

Finally, a serious drawback of section 1876 has been the requirement that all HMO Medicare members, including those enrolled in the HMO at the time the plan enters into a risk-based contract, agree to receive all Medicare covered services through the HMO. This imposes a significant hardship on the current Medicare members who are accustomed to Medicare reimbursement for out of plan services. A change in their habitual pattern of seeking health care would be traumatic, but under section 1876, the equally unattractive alternative is terminating membership in the HMO. There is need for a provision which would allow a reasonable transition to the new requirement.

S. 1509, the Competitive Health and Medical Plan Act, goes far in addressing the shortcomings of present law, and with a few modifications we believe the measure will create a workable mechanism to increase the availability of HMO membership to Medicare beneficiaries.

Under this bill and similar proposals, HCFA will calculate the average cost of providing Medicare services in the HMO's service area to a population similar in composition to the Medicare beneficiaries expected to enroll in the HMO, the adjusted average per capita cost or AAPCC.

The HMO will be paid, prospectively, 95% of this amount. Based upon information submitted by the HMO, HCFA will then calculate the HMO's adjusted community rate or ACR. With the HMO's premium for its non-Medicare members as a starting point, adjustments will be made to reflect the Medicare benefit package and a time and complexity factor appropriate to the added attention and care needed by elderly patients. Because the ACR is based upon the HMO's premium, the HMO receives a contribution to its capital retention, marketing and other appropriate costs which are attributable to the provision of services to its Medicare members. This means that with respect to its Medicare members, it recovers these costs in the same way that it does for its non-Medicare members. Any difference between the AAPCC and the ACR must be used for the benefit of the Medicare members.

We endorse the basic framework of this formula. It at last provides the HMO with a prospective fixed payment which places the plan at risk in the same manner it accepts risk for the provision of care to its non-Medicare members. All reimbursement in excess of the ACR must be returned to the Medicare members. It is the beneficiary who gains through the savings which are generated.

S. 1509 permits the savings to be returned to the beneficiary in the form of reduced copayments and deductibles, added benefits or cash rebates. We are very concerned about the option to provide cash rebates in all cases. HMOs are fundamentally providers of health care not dollars. An inherent characteristic of an HMO is prepayment, that is that health care is paid for when it is most affordable and not at the time of sickness or injury when it is least affordable. Cash rebates are, therefore, inconsistent with the way HMOs do business and frustrate the overall purpose of the legislation

to accommodate Medicare reimbursement to HMOs. If rebates are to be seriously considered, they should be designed specifically to meet special situations.

We believe that Medicare funds should be used to directly increase and improve the delivery of services to the elderly population they are intended to benefit. This bill quite rightly permits the HMO to structure the use of these savings in the manner most suited to its particular Medicare population and allows the HMO to offer a benefit package richer than Medicare Part A and Part B services as its basic offering to Medicare beneficiaries if doing so will not substantially discourage enrollment. This latter provision will permit the HMO to treat its Medicare and non-Medicare members alike by offering them similar comprehensive benefit packages. We are concerned about the requirement that a group of Medicare members shall select the added benefits provided through the use of the savings. Sound marketing principles demand that the benefits offered respond to the needs and preferences of the Medicare members. The HMO's normal policymaking process would be circumvented, and the potential benefit is far from certain.

We support a provision such as that in S. 1509 which permits Medicare beneficiaries who are members of the HMO at the time it enters into a risk-based contract to elect to continue to receive their care on a cost-basis. This provision recognizes that it is difficult for the elderly to alter habits of freely seeking care outside of the plan, a practice not allowed under the risk-basis arrangement.

We also support the open enrollment enrollment provision in S. 1509. HMOs will be required to enroll Medicare members during open enrollment periods designed to make the plan readily available to a representative cross-section of the eligible Medicare population in the community. In the process of attracting and enrolling Medicare

beneficiaries, HMOs develop marketing techniques which both reach the elderly and accurately inform them of the benefits and obligations of HMO membership. However, requiring the HMO to regularly provide information about the HMO to all Medicare eligibles in the area imposes a burden on the plans which they cannot realistically meet. We would be willing to cooperate with the staff to develop a workable provision.

S. 1509 requires that the contracting entities be federally qualified or state licensed HMOs or competitive medical plans meeting a somewhat broader definition with adequate safeguards for the Medicare members. We urge that plans falling within this last definition be required to offer preventive services in addition to physicians' services, inpatient hospital services, laboratory, x-ray and emergency services and out of area coverage. This will assure that all plans, HMO or non-HMO, will compete on an equal basis. It also assures that the full benefit of the system is available to the Medicare enrollees regardless of the plan they select.

Finally, we strongly urge that an HMO's option of electing to serve Medicare members on a cost-basis under the current section 1876 be retained. It may be more appropriate for a plan, because of its size or age or lack of sophistication or other valid reasons, to contract with HCFA on a cost-basis for the provision of Medicare Part A and Part B services.

S. 1509 is based on sound principles. It can afford Medicare beneficiaries sorely needed benefits without unconscionable costs to them or to the government. We are grateful, Mr. Chairman, for the opportunity to express our views on this important legislation, and we would be happy to offer suggestions for the modifications we have discussed.

STATEMENT OF

GERALD L. COE

ACTING CHIEF EXECUTIVE OFFICER

GROUP HEALTH COOPERATIVE OF PUGET SOUND

BEFORE THE

SUBCOMMITTEE ON HEALTH OF THE SENATE FINANCE COMMITTEE

ON

METHODS OF REIMBURSING MEDICARE PROGRAMS OF

HEALTH MAINTENANCE ORGANIZATIONS

JULY 30, 1981

WASHINGTON, D.C.

Mr. Chairman and Members of the Committee,

Group Health Cooperative of Puget Sound (GHC) is the largest consumer-owned and directed health maintenance organization in the country. During the more than 33 years of our operation, we have grown to currently serve more than 283,000 individuals. Services are provided through a network of our own facilities, including two hospitals, thirteen medical centers, and an extended care facility. GHC was originally established by a group of consumers alarmed by the inability of people to obtain needed health care services at an affordable cost during the Depression; these individuals committed themselves to promoting individual health by making available comprehensive personal health care services to meet the needs and desires of the persons being served and to reducing cost as a barrier to health care.

An obvious outcome of GHC's original precepts is the commitment to care for our elderly enrollees, most of whom are Medicare beneficiaries. In fact, Medicare's objective of freeing beneficiaries from the fear of costly medical bills sounds reminiscent of the founding philosophies of Group Health Cooperative. To that end, it would seem consistent that our organization entered into a Medicare agreement effective July 1, 1966, the first day of the Medicare program. Ten years later, we became the first, and to this date, only participant in the risk-sharing program established by Congress in 1972 under Section 1876 of the Social Security Act. Our Medicare enrollment in that program now numbers close to 24,000 beneficiaries, constituting some 8% of our total enrollment.

I am particularly pleased, therefore, to speak to you today about proposed reforms in the present reimbursement mechanism for the care provided to Medicare beneficiaries by health maintenance organizations. In doing so, we will attempt to discuss our five years of experience under a Section 1876 risk-basis contract, the problems with the present law, and the extent to which these are addressed in S. 1590.

When the Medicare program was first enacted in 1965, it did not recognize HMO's as alternative and competing delivery systems. The reimbursement mechanism was developed around the fee-for-service system and retroactive cost funding with no provision for prospective reimbursement, the basic method by which HMO's are paid for their non-Medicare members.

In 1972, the Congress added Section 1876 to Title 18 of the Social Security Act. This section, in providing for a new method of payment for HMO's, represented the first attempt to recognize alternative modes of practice, and sought to capitalize on the well-documented cost efficiencies of HMO's and provide an incentive system for Medicare beneficiaries' use of HMO's.

As it currently reads, Section 1876 incorporates elements of risk, incentive, and protection against overzealous cost efficiency. Generally, it provides for a capitation payment for both Part A and B services on either a cost or risk basis and establishes the important principle that an HMO that chooses a risk contract would receive some of the savings which result from its efficiencies. Savings are determined by taking the annual costs incurred by the HMO in providing services to its Medicare members and comparing those to a federal government estimate of what would have been paid by Medicare if the

same service had been provided in the fee-for-service community (the Average Area Per Capita Cost, or AAPCC). If the HMO's costs compare favorably, the "savings" are shared by the HMO and the federal government. Section 1876 limits the HMO's share to a maximum of 10% of the AAPCC. The risk inherent in the arrangement is that if the HMO's costs exceed the AAPCC, the HMO must absorb the entire excess amount.

The present law, however, does contain several problems. First, and probably most significant, is the requirement that final payment to the HMO is made retrospectively and may not be determined until two or three years after services are provided.

Second, the present law provides that when an HMO enters into a risk contract, all its existing members must agree to obtain all their Medicare covered services through the HMO or terminate their membership (the "lock-in" feature). Since under other existing arrangements Medicare pays for services received outside the HMO, this change or "lock-in" feature of the law has been rather traumatic for many of our Medicare enrollees.

Finally, there is no requirement in Section 1876 that the savings realized by the HMO must be passed on to the Medicare members.

Since GHC is the only HMO in the country operating under the existing Section 1876 provisions, our experience may prove useful to your consideration of the proposal before you.

In October of 1976 Group Health Cooperative began its risk-sharing program. Initially great resources were devoted to converting cost reporting systems, to converting enrollees to the new program, and to working with Medicare (the Health Care Financing Administration, or HCFA) to develop rules and regulations for implementing the program. Now, some five years later, the program is undoubtedly more sophisticated and effective.

One of the obvious parameters of performance under a risk-basis contract is the cost experience. Table 1 presents the per member per month costs of GHC compared to the AAPCC for each year. The savings achieved have been significant, both for GHC and the federal government. However, the per member savings have declined each year. In the fifteen-month period from October 1976 through 1977, GHC adjusted costs were 33% lower than the AAPCC; in 1979 the costs were estimated to be 10% lower.

Table 1. Cost Comparison

	GHC Adjusted Cost	AAPCC	GHC Savings PMPM*	Fed'l Gov't Svngs PMPM*
1976-1977	$48.66	$62.90	$6.29	$7.95
1978	59.71	70.46	5.38	5.38
1979	71.01	78.70	3.85	3.85
1980**	78.65	91.80	6.58	6.58

*Per member per month

**Final settlement not yet determined

As previously mentioned, the current Section 1876 provisions do not specify the uses of the savings received by the HMO. It has been our policy, however, that all savings should be used for the benefit of our Medicare enrollees. To date, a total of $3.4 million has been used exclusively to (1) reduce dues charged to Medicare enrollees to cover the copayments, deductibles, and extended benefits not covered by Medicare and (2) to increase benefits for Medicare enrollees without increasing dues. The proposal before you specifically requires that the savings be used for the Medicare beneficiary, a requirement that we support as an improvement of the program.

As indicated in Table 1, the per member monthly reduction in dues resulting from the savings generated have ranged from $6.29 in 1976-1977 to $3.85 in 1979. The size of the return to the enrollees is a crucial element of the incentive plan; unless the return is visible to the Medicare beneficiaries, they may be unwilling to remain enrolled or to seek enrollment in the HMO. Additionally, the return must be demonstrable enough to overcome the beneficiaries' opposition to the constraints of the "Lock-in" provision.

A second performance indicator is the number of individuals choosing to enroll under a risk-sharing contract. In 1976, the Cooperative had approximately 13,000 Medicare beneficiaries enrolled. Each individual underwent a conversion process of deciding whether to enroll in the new program with some refusing to accept the "Lock-in" provision and disenrolling from GHC. Since

that time, the Medicare enrollment has increased to some 24,000 beneficiaries. Because of the size of our organization, the majority of this increase has been made up of individuals who "aged into" the Medicare plan after already being enrolled in GHC prior to reaching age 65. The remainder entered through annual open enrollment periods during which no applicant was refused enrollment in our basic Medicare option.

Results of the annual open enrollment efforts prove instructive. The most recent enrollment effort at the Cooperative extended from July, 1979 through August 8, 1980, a fourteen-month period. During that effort, H.C.F.A. mailed letters to approximately 260,000 Medicare beneficiaries in the Puget Sound area, announcing the opening. In addition, the Cooperative launched an expensive and comprehensive advertising campaign. Table 2 summarizes the results of the effort to elicit enrollment.

TABLE 2. 1979-1980 Open Enrollment Effort

Telephone inquiries to GHC	11,291
Applications requested	2,593
Individuals electing to enroll	2,093

These results indicate several problems with the process. Certainly with the combined efforts of HCFA and the Cooperative, beneficiaries were well informed of the opening. In fact, the telephone response was sizable. Holding an open enrollment effort of fourteen months assured plenty of time for individuals to seek enrollment. However, several factors potentially detract from the appeal of the program:

1. The "Lock-in" provision - this provision evokes marked opposition from individuals, new applicants and current enrollees alike.

2. Established relationships with fee-for-service practitioners - under the terms of the program, with a staff model HMO such as GHC, the enrollee must establish a new relationship with HMO's practitioners.

3. Initial misperceptions about HMO's - these may prohibit even consideration of joining. Alternatively, as applicants learn more about the plan, they may realize the program differs from their expectation.

4. Cost - as limitations on coverage, coinsurance, deductible rates, and disallowances increase in the federal Medicare program, HMO dues must increase. Unless the savings share is substantial enough to reduce this cost noticeably, beneficiaries may not be able to afford the plan.

Another problem with the open enrollment process is the potential enrollment of far more individuals than expected. As the first HMO to hold an open enrollment period, Group Health Cooperative had no idea whether 300, 3,000 or 30,000 individuals might seek enrollment. Furthermore, our experience has been that our Medicare enrollees use hospital services at seven times the rate of our non-Medicare enrollees. Underestimation of potential Medicare enrollment for an organization that owns and operates its own hospital facilities can dramatically increase bed use and create unexpected bed shortages. The net impact on our organization is that any unexpected enrollment forces us to plan

and build hospital beds seven times as fast as we would otherwise. Concomitantly, costs of constructing the needed beds increase the cost to the enrollee.

One final element that has affected us dramatically has been the multiple retroactive adjustments to our AAPCC. In 1978 and 1979, for example, three adjustments were made to the original estimated AAPCC, decreasing the amount by 12% and 14% in those respective years. Initial estimates are not available early enough to be incorporated in our budget process, nor has the actual AAPCC and resultant savings share been determined until as much as three years following the contract year. This lengthy delay with the likely adjustment downward from previously estimated savings places an organization at risk in trying to pass the savings on to the Medicare population. Since the HMO develops a yearly budget based upon prospective prepayment by all enrollees, the incompatibility of this delay is clear. It also provides a clear illustration of the incompatibility of a retrospective or cost reimbursed system and the prospective HMO system.

Because of our experience with the retroactive risk-sharing program, we strongly support the proposal under consideration by this committee to establish a truly prospective system. For Group Health Cooperative, this would represent the only real change in our current program. The prospective system would allow us to budget dues reductions using the savings share on a timely basis. However, in order for the program to work, the AAPCC must be determined early enough for the HMO to determine whether it can continue in the risk program.

In addition to the above, there are several other provisions we feel should be considered for inclusion in the proposal before you. First, as allowed under present law, GHC has elected to have Medicare process Part A claims. It is our position that this option should be continued. Current law allows the HMO the option of continuing on a cost basis arrangement. This should be continued. This is extremely important for those new HMOs with small Medicare enrollments, little experience with beneficiaries, and an inability to absorb financial risk. Lastly, again under the present program, the Secretary is not limited in terms of the factors which may be considered in defining appropriate classes of members. Under the proposal before you, only the factors of age, sex, institutional status, disability and health status, and place of residence may be considered. We consider it important to insure that all potentially relevant and measurable factors may be considered in future development and refinement of the AAPCC.

With the establishment of prospectivity, and with efforts to ensure the HMO enrolls beneficiaries comparable to the fee-for-service community, the HMO can provide a more cost efficient, comprehensive alternative. It can achieve these efficiencies through shorter lengths of hospital stays, fewer hospital admissions, and lower administrative costs; these factors have been well documented. Further, the legislative proposal will reward the beneficiaries who select a more cost efficient approach to health care and accept the accompanying limitations. This will ensure the availability of comprehensive care for Medicare beneficiaries and cost savings for the federal government.

Senator DURENBERGER. Our next witness is Dr. Richard YaDeau, National Council of Community Hospitals, St. Paul, Minn.

Dick, we appreciate your being here today.

STATEMENT OF DR. RICHARD E. YaDEAU, NATIONAL COUNCIL OF COMMUNITY HOSPITALS, ST. PAUL, MINN.

Dr. YADEAU. Thank you, Mr. Chairman.

I am Dr. Richard E. YaDeau. I am a surgeon in the fee-for-service community, in St. Paul, Minn.

I am president of the Bethesda Health Care Organization which is a health care organization, organized to respond to the medicare prepayment experiment.

I am a personal member of the National Council of Community Hospitals. I appear here today on their behalf.

It is an organization composed of hospitals and interested individuals who are working for reform within the health care community.

I am committed to a development of a new and more effective health care delivery system. The public interest requires that there be a fundamental change and restructuring of the delivery and financing system.

I feel that the reasonable cost and reasonable charge reimbursement must be replaced by a financing system which makes hospitals and doctors economically sensitive.

We must be able to compete on cost, as well as on quality, and be able to bear the consequences and the benefits of our economic calculations.

To do this hospitals and physicians must be organized into economically competitive units. Then patients and those who care for them, physicians and others, could begin to make decisions as to how their care should be delivered and how it should be paid for.

Our health care organization is the first step that physicians and hospitals must make if they are going to take themselves into the future and create a restructured health care system that meets these goals.

Because of the trial nature of the medicare experiment our only opening into this market in the St. Paul area was through Blue Cross/Blue Shield. This has, by its very nature, limited our success in signing up medicare beneficiaries.

Blue Cross/Blue Shield, in our area, through July 1, 1981, had rejected 90 percent of its applicants.

This past month, through hard work, they tell us they have it down to only an 80-percent rejection rate.

Doctors are interested in caring for patients and are prohibited under this sort of activity from doing so.

While other health care organizations in our area are functioning well below 10 percent, Blue Cross/Blue Shield has a 20-percent overhead. It is removed from the system before it is provided to the deliverers of care under its organization or framework.

The turn around acceptance time was supposed to be 90 days, but the first people who applied for acceptance in February of this year were not accepted until the first of July.

There has been little assurance to the people that there will be coverage guarantees after the trial period.

In essence, then, I feel that by having a limited marketplace and a trial program with Blue Cross/Blue Shield that is in the market, we have been in a self-defeating situation.

The image and posturing of the Blues in our community is not such that it bespeaks to effective HMO activities.

Despite these difficulties, I feel we must restructure the system without working through experiments. I feel if you can change the incentive, the system will change without additional bureaucratic control.

I appreciate that in S. 1509, you would introduce into law the current medicare experiment. If the law is written in such a way as to avoid the access problems that organizations such as ours have to a patient community, and introduces competition on a fair and effective basis, then I feel it would serve as a first step toward total reform of our entire system.

Any law must, as S. 1509 does, prohibit plans from excluding bad risks. Without open enrollment, plans will compete on who they can sign up rather than in terms of quality or efficiency.

Plans, additionally, must have full price freedom. Payments cannot be based on the cost of the same services in the nonprepayment plans.

In essence, we need the opportunity to price ourselves in a competitive market with a like patient mix.

What is needed then is the ability to phase out reasonable cost-reasonable charge reimbursement and a cap on the amount of what employers pay in premiums for nonmedicare patients can be excluded from taxation.

We need to institute broad price competition. We have to eliminate planning control. We need assistance for the needy to obtain the most effective health care cost.

H.R. 850 comprehensively deals with these issues. We commend it to this committee on its own merits. But, furthermore, as a blueprint for how a restructured system might operate.

Thank you.

Senator DURENBERGER. Thank you very much.

I might disagree with a couple of points you made, but I find myself hard pressed to find a question to ask you because you so thoroughly laid out your case for the future of health care delivery.

Let me ask you one, though. You mentioned administrative problems and the crossfire, I think this was in the written statement, the crossfire between Colonial Penn and Prudential.

I asked one of our earlier friends from the Twin Cities about competition that is going on out there between HMO's and between HMO's and the private sector, about the implication of that competition on the enrollment of seniors into this program.

I would just ask you to comment on what factor if any some of this competition might have in the problems with current enrollment or what judgment we ought to draw from the nature of that competition about how we get into these medicare programs in the future.

Dr. YADEAU. Mr. Chairman, the 88 physicians in our health care organization have really been unable to proselytize and move patients, the elderly, who are parents of their patients, into the Blue Cross/Blue Shield program which is the only access we have under

the trial model, when they know that only 10 percent of them are going to be accepted and the patients can achieve acceptance in either the Colonial Penn or the Prudential model.

So, responding to their patients as people for whom they are concerned, they had to encourage them to move away from the very care plans which they would like to have seen them join, because of the restraints of incorporating people into the system.

The Blues have been disallowing people for cataracts.

Now there is an interesting one. They only have two risk exposures. I never heard anyone who has a third.

They have said that people who have high blood pressure are risk excluded.

You ask any physician what a person's reasonable blood pressure is after the age of 60, you would have the patient's age, plus 100.

Yet, if somebody comes in at 70, with a blood pressure of 170 systolic, they are disallowed.

Basically, any person who has had any touch of elevated blood sugar diabetes, is on any cardiaregulatory drug of any sort is disallowed.

It is a system designed to prevent us as physicians from caring for sick people.

Senator DURENBERGER. Let me ask you one other question that does occur to me, because you are really very flatout against experiments and demonstrations and things like that. I have a tendency to be that same way when I look around and see if there is enough experimentation going on now.

But, I am impressed by what I have heard here today in the couple of hours we have been at this so far about the values that there are to be learned about different things and different communities and so forth.

So, expand a little bit more on why you are telling policymaker and the author of one of the other let's get to the marketplace bills, other than the one you mentioned, why you are so opposed to experiment?

Dr. YADEAU. Mr. Chairman, if you really believe in competition, you should allow all of us who share those beliefs with you to share in that competitive marketplace. By having a limited trial which precludes a lot of us from effectively playing the game you have laid out for us, we are restrained from endorsing, and in fact working with you on your programs.

Senator DURENBERGER. The problem then is, we, meaning HCFA or the Federal Government, went to a marketplace and said, meaning, we went to all the senior citizens organizations and all that sort of thing, and we said, "Here is the experiment."

Dr. YADEAU. That's right.

Senator DURENBERGER. That's right.

Dr. YADEAU. Yes.

But it did not allow the broad group of us to respond to the experiments and say to you, "We will play the game with you. We will be responsive to our patients. We will be cost sensitive."

Senator DURENBERGER. Thank you very much for your testimony and for being here today.

Dr. YADEAU. Thank you.

Senator DURENBERGER. I am sorry. Senator Bradley, do you have a question?

Senator BRADLEY. Mr. Chairman, I don't have a question. I have not had a chance to look at the testimony. If I do, I would like to submit it in writing.

Senator DURENBERGER. Fine.

Thank you.

[The prepared statement follows:]

TESTIMONY OF

DR. RICHARD E. YADEAU

BEFORE THE

SENATE FINANCE COMMITTEE

July 30, 1981

NATIONAL COUNCIL OF
COMMUNITY HOSPITALS

My name is Richard E. YaDeau. I am a practicing surgeon in St. Paul, Minnesota, and am President of the Bethesda Health Care Organization (HCO), a pre-paid health plan which is participating in the Medicare pre-payment experiment. I am a personal member of the National Council of Community Hospitals and am appearing on its behalf. NCCH is an organization composed of community hospitals and interested individuals from around the country who are working to reform the health care delivery system.

As is apparent from my participation in the Bethesda Health Care Organization, I am committed to the development of new and more effective health care delivery systems. I believe that the public interest requires a fundamental restructuring of our present health care delivery and financing system.

Reasonable cost/reasonable charge reimbursement must be replaced by a financing system which makes hospitals and doctors economically sensitive. Patients themselves should have incentives to compare various types of health plans and to make decisions which are based upon economic, as well as quality, considerations. Doctors and hospitals should be forced to compete not only in terms of quality as they do now, but on price, and they should bear the consequences of their economic calculations. This price must be pre-determined so that providers do not have automatic

economic incentives to provide more care. New arrangements must be entered into between hospitals and doctors to bring them together in integrated delivery and economic systems.

I believe that patients and those who treat them are better able to determine how health care should be delivered and how much should be spent for it than is the government. Economic competition, therefore, should replace the complex and stifling bureaucratic and planning controls under which we now suffer.

The Health Care Organization (HCO) which we have organized to participate in the Medicare experiment is a first step in the direction of restructuring the health care system to meet these goals. We have carefully selected the physicians who will participate to ensure that we are working through physicians who not only provide high quality care but who can be counted upon not to over-treat, over-prescribe, and over-admit. Both the physicians and the hospital are at financial risk for overutilization, and both benefit from increased efficiencies.

We can compete by providing a better service to the patient at a reduced cost to him. However, our success in signing up Medicare beneficiaries has to date been limited. This has resulted from the natural inertia of people, particularly the elderly, compounded by a number of problems in the administration of the project.

Medicare and More, the Blue Cross/Blue Shield program, has refused to accept as members 90% of the people who have applied for membership in our HCO on the ground that they were not satisfactory risks. Blue Cross/Blue Shield apparently is taking the position that anyone who has any possibility of becoming sick should not be included in the experiment. Indeed, one of the screens, I was told, provides that a person "heading for cataract surgery" is excluded from membership. That and similar screens have made it difficult to sign up the elderly.

Also, we have recently discovered it is taking as long as ninety days to have people accepted for membership in the plan. We must send the names of applicants to HCFA to assure eligibility -- a process that takes approximately ninety days. That delay does not make it any easier to obtain members.

Further compounding our difficulties is the fact that Medicare and More has felt itself obliged to require us to give applicants notice that there is no guarantee that they will be eligible for supplemental coverage at the end of the three year experiment. Needless to say, this does not provide an incentive for an elderly person to sign up with the program. The elderly are more likely to look for a policy which will guarantee them continuity of coverage.

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Despite the relatively large amount of money being spent for administrative and advertising purposes, we have not developed sufficient marketing expertise, and our marketing materials are poorly conceived and uninspiring.

We have also been caught in the cross-fire of the highly-publicized competition between The Prudential Insurance Company of America and Colonial Penn Insurance Group to provide insurance to the members of the American Association of Retired Persons. The multiplicity of plans offered in the Twin Cities area makes it more difficult for the senior citizens to be able to choose. This is aggravated by the fact that the AARP competition obtained far greated publicity than the prepayment plans could generate. This focused the minds of the elderly on the competition between the two insurance companies rather than on the competition between them and the prepayment plans. The benefits of joining the prepayment plans were lost in the greater publicity generated by Prudential and Colonial Penn.

The AARP plans, as presented, are attractive, particularly with respect to the absence of tight screening and the assurance of continuity of coverage -- two problems, which as I discussed above, have made our plan less attractive.

As I mentioned before, membership in our HCO has been delayed because the required HCFA approval takes ninety days. The deadline imposed by the AARP plans meant that people could not wait for the ninety days. They had to take the bird in hand of an AARP plan rather than risk losing that possibility in the hope that they might be accepted into our plan.

But these difficulties do not change my belief that we must restructure the system and that it can be done. Rather they suggest the difficulty of trying to work through experiments. If the incentives are changed, the system will change, without the need for bureaucratic control of the change -- control which may in fact keep it from occurring.

The Committee will soon be considering proposals, such as S. 1509, which would in effect introduce into law the current Medicare experiment. If the law is written so as to avoid the problems we have experienced and to introduce competition on a fair and effective basis, Medicare reform could serve as the first step toward reform of the entire system.

Any law must, as we understand S. 1509 does, prohibit participating plans from excluding the bad risks. Open enrollment must be required of competitive plans; if it is not, plans will compete not in terms of quality or efficiency, but on who can sign up the best risks.

Also, competitive plans must have full price freedom. The necessary distinction between a competitively determined price and the amount of government assistance must be recognized. Plans' income cannot be determined by HHS' decision on what the cost of providing the same services in non-prepayment plans would be and then supplying the prepayment plans some percentage of that amount. This is a subjective and difficult analysis. It gives HHS rate-setting authority.

Conversely, tying plans' payments to an estimate of others' costs prevents the full benefits of price competition from being realized. It gives plans an amount which is slightly below the level of the fee-for-service sector, depending upon where the Secretary sets the amount of payments to plans. This would give prepayment plans a free ride on the prices determined by a cost-increasing system. The benefits of competition can better be obtained by requiring all providers to compete in terms of price as well as quality, rather than paying some organizations slightly less than an amount which is set on a non-competitive basis.

Plans whose prices are set by the Secretary and which enjoy a free ride on the existing system are not going to be sufficient to introduce a deregulated, competitive system. An effort in this direction will simply represent one more slight adjustment in the present system. What is needed is

a fundamental restructuring. We urge the Committee to consider proposals to phase out reasonable cost reimbursement, to put a cap on the amount of employer-paid premiums which can be excluded from tax, to institute price competition, and to eliminate planning control, while at the same time providing needed assistance to Americans to obtain health care. The National Health Care Reform Act (H.R. 850) comprehensively deals with these issues. We commend it to the attention of this Committee on its own merits, and also as a blueprint for how a restructured system should operate, even if change is made incrementally.

SUMMARY OF TESTIMONY OF
DR. RICHARD E. YADEAU

1. The present reasonable cost/reasonable charge reimbursement system must be replaced by a health care delivery system which makes doctors, hospitals and patients cost sensitive.

2. Competition among providers, in terms both of quality and price, should replace government economic regulation.

3. New arrangements between hospitals and doctors must be developed to bring them together in integrated health care delivery systems.

4. The Health Care Organization which we have organized to participate in the Medicare prepayment system is a first step in that direction.

5. Our HCO has been impeded in its ability to obtain members by a number of administrative problems.

6. These problems are inherent in experiments run by organizations which also are functioning in the present system. Reform can be achieved better by changing the economic incentives of the health care delivery system than engaging in experiments.

Senator DURENBERGER. Our next panel is a panel of two, Ellis J. Bonner, president and chief executive officer of Comprehensive Health Services of Detroit, Detroit, Mich., and Howard R. Veit, director, New York State Office of Health Systems Management, Albany, N.Y.

Gentlemen, thank you for your patience. I will have to thank Dr. Ellwood twice, since he is going to be the most patient person here today.

STATEMENT OF ELLIS J. BONNER, PRESIDENT AND CHIEF EXECUTIVE OFFICER, COMPREHENSIVE HEALTH SERVCIES OF DETROIT, DETROIT, MICH.

Mr. BONNER. Mr. Chairman, my name is Ellis Bonner. I am the president and chief executive officer of Comprehensive Health Services of Detroit.

I am also the president of the Association of HMO's in the State of Michigan, which is comprised of 12 health maintenance organizations. I would like to point out that of those 12 health maintenance organizations in our State, 7 of them have contracted with our State agency for medicaid contracts.

We have not suffered because we dared to contract with a State agency for delivery of services to medicaid eligible recipients. All are fiscally viable.

I have been one of the more vocal opponents of what I saw as flaws in regulations which have governed HMO's, and which have precluded them from participating with State agencies as far as medicaid recipients are concerned.

I have repeatedly taken exception to the 50–50 rule for which I want to congratulate the Congress in that it is sensitive enough to the inequities of this regulation, that it is considering lowering the ratio to a 75–25 mix.

That is still, in my estimation, not realistic, sir.

I would like to further convey to the Congress and to this subcommittee, that unless the Secretary has waiver powers, based on the socioeconomic and demographic mix of a given area, then the 75–25 rule is not realistic.

The waiver has been applied to public entities. However as I read the proposed law, but if it does not include similar consideration for private HMO's. This does not deal with the real world.

I speak of these matters today for the HMO industry with medicaid contracts and because I head, in the estimation of many, the most successful HMO in the United States with a medicaid contract.

I lay and I attribute much of our success to the wholehearted cooperation of the State of Michigan which has created an environment within which HMO's can grow. They have built in incentives into all of our agreements. No HMO in its right mind will take on a medicaid contract unless the environment is conducive to it remaining viable.

Further, there are other considerations which have to be looked at in various areas in the country.

In our own area of Detroit, we have an antiunion stance toward HMO's and we are in a uniondominated city. Unless they happen

to be controlled by the union, these HMO's are not permitted to address these services to the constituency of the unions.

Further, I think that if you want HMO's to enter into the medicare-medicaid contracts, the States are going to have to have more latitude in the negotiating of those contracts, based on a number of factors that might be present in their particular locale.

An HMO must first of all not be cost conscious, but first of all be quality conscious of its health services.

Senator DURENBERGER. Be what?

Mr. BONNER. Quality conscious.

Then I think cost consciousness comes into play and last, but not least, I believe an HMO should have a social conscience, something that ironically applies apparently only to those HMO's who have dared take on a medicaid contract.

It is a cruel irony that those who choose not to market to the underserved and to medicaid populations—and that is the majority of HMO's in our country—escape the problem, while those of us who have accepted the challenge and responsibility, are made to pay for our daring and our ability to take on a problem that society seems to want to escape from.

We have done it. We have been successful. We have in excess of a $12 million reserve which we are returning to our subscribers and to taxpayers in the form of new facilities and additional services.

If we can do it in Michigan, we believe it can be done anywhere in the United States.

Thank you, sir.

Senator DURENBERGER. Thank you very much.

Howard, you have been here before. We are going to see more of you in the future, I hope. I am very committed to doing some things about community health planning.

STATEMENT OF HOWARD R. VEIT, DIRECTOR, NEW YORK STATE OFFICE OF HEALTH SYSTEMS MANAGEMENT, ALBANY, N.Y.

Mr. VEIT. It is a pleasure to be here. I find myself as a State-level regulator completely in agreement with the comments that Mr. Bonner has made.

You may know, Mr. Chairman, that before assuming my duties as director of the Office of Health Systems Management in the State of New York, I was director of the Office of Health Maintenance Organizations with the Department of Health and Human Services and have a very, very strong interest not only in cost containment, but believe very, very strongly that one method of cost containment that is injecting more competition in the health care system is clearly the way we should go in the way of public policy.

You may also know that New York State has had a long, infamous record in the area of imposing regulations, particularly cost containment regulations on its health care providers.

I am very pleased to say to you today that we consider one of our more important efforts relative to cost containment in New York, particularly as it relates to the medicaid program, which in New York State, is a huge percentage of our total State budget, attempts to enroll more medicaid recipients in HMO's.

We have not been overwhelmingly successful in doing that, but we have a very, very directed strategy toward trying to overcome the problems of the past of getting medicaid recipients in HMO.

There are three or four areas that I would just like to quickly hit on which I consider to be, in terms of State policy, to be important in terms of encouraging more medicaid enrollment.

First, is contract negotiations that relates to the establishment of rates between the State and the HMO.

I would echo what Mr. Coe said and Mr. Lane said earlier about the importance of prospectivity, in terms of rate setting for HMO's. Whether it be medicare or medicaid, HMO's do business on the basis of a prospective reimbursement method, should not be subject to retrospective audits, retrospective cost adjustments, should be able to do business relative to a risk basis with the States.

But, I would say this. Many HMO's that have not served medicaid recipients, and that is the majority of HMO's, do not have the proper actuarial experience relative to medicaid populations. That is, they don't know what utilization will be with the medicaid population.

Therefore, we urge in New York State and we would urge as Federal policy, basically a two-stage approach to setting rates with HMO's which would make it easier for the HMO and easier for the State to enter into contracts.

Stage No. 1 would allow the State and the HMO to enter into something other than a risk contract for the first year or two so the HMO can gain some experience in serving the medicaid population.

We would propose this maybe for the first 2 or 3 years of a contract.

Following the first 2 or 3 years of a contract, we would suggest that the State and the HMO be required to go into a risk based contract. It is at this stage, Mr. Chairman, that stages and the Federal Government, with, of course, their matching amount on the medicaid program, will begin to realize its most significant savings.

But, I am strongly in favor of easing into risk with HMO's on medicaid rather than requiring them at the outset in year one.

Second, and equally as important is the area of regulation imposed by the States on HMO's. New York State currently overregulates HMO's. The survey process is too rigorous. We conduct surveys of HMO facilities, both at the State level, and if you happen to be an HMO in New York City, you get surveyed by the city as well.

The regulations, I think, are far too detailed. We are in the process, particularly by virtue of our largest medicaid contract, that is, with the health insurance plan of Greater New York, attempting to greatly deregulate that contract, so that the State and the city would work together relative to surveying facilities and so that we would begin to reduce the level of regulation.

But, at the same time, maintain our responsibility to protect the member and make sure that quality services are provided to the medicaid recipients.

We are very cognizant of the situation in California where medicaid mills, in prepaid health plans, developed a bad reputation for the HMO movement in the early 1970's.

We don't plan on deregulating to the extent that we get to that point. But we think many States, including our own, overregulate HMO's, thereby making it a disincentive for HMO's to participate.

Finally, I would just like to say that I agree with Mr. Bonner on the 50-percent requirement. We are in New York, in favor of that, removing the requirement that HMO's have at least 50-percent private enrollees in order to enter into a risk contract.

We would frankly, like to see that requirement eliminated, but if not eliminated, raised to 75 or 80 percent.

Marketing is a big problem for HMO's, in the medicaid population. Most HMO's must resort to door-to-door marketing in order to get enough enrollees, because there is current, under the Privacy Act, prohibition on the part of the States of releasing lists of medicaid eligibles to HMO's.

Door-to-door marketing is inefficient and often causes, has been the result of abuses on the medicaid recipient.

We would like to see regulations at the Federal level that would allow the States and the HMO's to work more creatively together to impose, to allow marketing methods to medicaid populations that would encourage enrollment rather than discourage enrollment.

Thank you.

Senator DURENBERGER. Thank you.

I don't know if you know by now, we tried to get rid of the limitations on HMO participation under medicaid, in this body and the House did not. But I think the reconciliation bill goes a long way toward greater flexibility. The House insisted on hanging on to a couple of requirements.

Maybe they will be more enlightened next year.

A couple questions. First, Mr. Bonner, all I have heard is, you know, how medicare is simple; medicaid is really tough when we talk about HMO involvement. But I see some astounding percentage here of your enrolled population are medicaid recipients.

I just heard Mr. Veit say, he gave us some recommendations for starting out not at risk and gradually moving into risk point.

Why don't you tell us why you are so dog gone successful with the medicaid recipients and what we could learn from that experience?

Mr. BONNER. We have had a close association with our State agency from the very inception. I had the privilege of negotiating the first contract in 1971.

They have assisted us in our marketing process by even putting out pamphlets to those who are eligible in our particular area.

They have now escalated that campaign to other counties in the State since it appears that the Federal Government is going to give us some relief on the 50–50 law. The State is more or less opening up the throttle in marketing medicaid to its eligible recipients.

We feel that it is inconsistent for the Congress on one hand, to acknowledge the fact that an HMO saves from 10 to 40 percent, and then give them a State medicaid card which is virtually a carte blance for medical services.

We have drawn that to the attention of our State legislators. We say you are a bit inconsistent. I am almost tempted to say that to

Congress, unless something is addressed to make the law consistent with the practice.

Senator DURENBERGER. In the whole business of savings and marketing those savings, where do you come down on cash rebates, premium rebates, increased benefits.

What would your recommendation be to others in that regard?

Mr. BONNER. Sir, I think I would rather not answer that, because I have gotten into some difficult arguments as far as rebating savings. I think this is what you are asking about rates to the recipient.

We need to explore other initiatives that will provide incentives to the the eligible recipient to approach the prepaid movement for services which have now been proven to be high quality, accessible, available, and acceptable.

There have been a number of suggestions for improving the benefit package. Some have indicated that we share the savings with the recipient as well as with the State.

I am not fixed on just what recommendation would be best there. Am I addressing the question you wanted?

Senator DURENBERGER. Yes. That is my question, exactly. If we are going to share with the—or should we share with the recipient, and if we are, which route do we best go. I understand that you are reserving judgment.

Mr. BONNER. It gets to a much thornier matter and that is the matter of right of choice. There are some who would limit the choice of medicaid recipients to those plans which have been approved by a set of criteria established by the State.

I believe a recipient should have the right of choice, but not a choice between the Cadillac and the Ford, when the Ford will take you anywhere the Cadillac will take you, if I might use that metaphor. Since I am from Detroit, I think I can.

But, nevertheless——

Senator DURENBERGER. You missed Chrysler. [Laughter.]

Mr. BONNER. Well, the chairman of our board is a Chrysler vice president. I know I could have used them. [Laughter.]

But, anyway, I really don't know. We get off into an area that I have read in the congressional discussion, but I don't think I ought to make a recommendation in this area, because it has not yet been explored to the extent that I feel comfortable in making a recommendation.

Senator DURENBERGER. One last question of both of you and that deals with people moving in and out during the course of the year and how that affects budgeting and all the rest of that sort of a thing.

What can we learn from your experiences?

Mr. VEIT. Well, one of the most serious problems and disincentives to HMO is rapidly fluctuating memberships. I think there are really two kinds of—two aspects to this problem.

One is fluctuating membership that relates to quickly changing medicaid eligibility, that is, the medicaid recipient goes on and off the welfare rolls quickly, therefore, becomes quickly uneligible for the HMO.

In New York, we are planning a demonstration where hopefully with the cooperation of the health care financing administration,

where any medicaid recipient, choosing the HMO, wouldn't in fact be guaranteed either a 60, 90, or 180 day, we would prefer a 180-day eligibility period which would be guaranteed and unchanged.

So, the HMO can have a somewhat predictable membership and a predictable flow of dollars to plan with.

The other area of fluctuating membership relates to voluntary disenrollments, that is, the member coming in to the medicaid recipient entering the plan and then choosing to leave.

In most cases, HMO's enroll their nonmedicaid population through a 1-year contract only to be changed at the anniversary date in the employer group. Medicaid recipients can come in and out at will.

We think that is bad and a disincentive to the HMO.

We would propose, on the one hand, is to protect the member by giving the member a 30-day period after enrollment to make up his or her mind as to whether they would like to stay in the HMO.

Once that 30-day period following enrollment were completed, we would recommend a 6-month lockin period where the medicaid recipient did not in fact have the option of leaving so that the HMO could have again, a more predictable enrollment level and not have to deal with fluctuating membership.

That is particularly relevant, Senator, in the sense that most HMO's do door-to-door for marketing for medicaid recipients. That is very expensive.

A high turnover of medicaid recipients, together with door-to-door marketing makes the cost of serving a medicaid population high and adds to the cost of the contract with the State.

Mr. BONNER. We have adopted the 6-months lockin period in the State of Michigan.

In addition, if there is a voluntary disenrollment, then those individuals, if they are eligible, are precluded from joining any other HMO for a period of 90 days.

We also are supportive of the congressional move to have the Federal Government's participation in maintaining eligibility where there would be otherwise a reason for eligibility for a period of 6 months.

This gives us a much stronger marketing stance. It stands as an incentive for more HMO participation in the State.

Senator DURENBERGER. Thank you both for your testimony. I appreciate it.

Mr. BONNER. Thank you.

Mr. VEIT. Thank you, sir.

[The prepared statement follows:]

TESTIMONY OF ELLIS J. BONNER

PRESIDENT AND CHIEF EXECUTIVE OFFICER

COMPREHENSIVE HEALTH SERVICES OF DETROIT, INC.;

PRESIDENT, THE ASSOCIATION OF HMOs OF MICHIGAN, INC.

BEFORE THE SUBCOMMITTEE ON HEALTH, COMMITTEE ON FINANCE,

OF THE UNITED STATES SENATE

July 30, 1981

Washington, D.C.

For Release:

9 A.M., July 30, 1981

Mr. Chairman and Members of the Subcommittee:

My name is Ellis J. Bonner. I am President and Chief Executive Officer of Comprehensive Health Services of Detroit, Inc. I am also President of The Association of HMOs in Michigan, Inc., an organization formed to pursue matters of common and mutual interest, including obtaining legislation conducive to the continued growth and effective functioning of HMOs in Michigan. It is an honor and a privilege to appear before you today to testify regarding Medicaid Prepayment Contracts.

The Congress has a right to be proud of its record in encouraging the development and functioning of HMOs as a means of introducing some badly needed competition into the health care marketplace. When HMOs were officially introduced into federal health care policy in 1971 by the Nixon Administration, there was little incentive in the fee-for-service world to stem the rising cost of medical care. Now, a decade later the HMO program has in your own words, Mr. Chairman, "earned a place in the American health care market." More specifically, HMOs have demonstrated their ability to:

1. lower health care costs;
2. provide comparable quality of care;
3. provide general membership satisfaction; and
4. provide appropriate and accessable health care in a comprehensive and coordinated delivery system.

Today, because of this demonstration, they can be seen to be a significant competitive force in the health care marketplace.

Of course, HMOs are not everything we want them to be. There are not enough of them. In particular, there are not enough of them operating in the very areas of medical programs under consideration today--the Medicaid and Medicare programs of the Social Security Act. Furthermore, and related to the above, there are not enough HMOs in the very urban and rural areas of the Country designated by the Congress as medically underserved.

To date, only about 270,000, or slightly over one percent of Medicaid eligibles, are enrolled in HMOs. Total public sector HMO membership equals only slightly more than six percent of the total prepaid membership in Federally Qualified HMOs.

In short, while the HMO system of delivery has proven itself, it has made a minimum penetration where the problems of affordable and accessible health care are most serious. It is my hope that in the course of re-examining the HMO program and the Social Security legislation, the Committee will focus squarely upon this anomaly.

As the President and Chief Executive Officer of Comprehensive Health Services of Detroit, one of the largest Medicaid HMO contractors in the United States, perhaps this is the area in which I can be of greatest assistance to the Committee. Let me review our

experience and history very briefly as a means of providing a perspective of prepaid Medicaid contracting.

THE PRESENT STATUS OF CHSD

CHSD stands today as a good example of a successful HMO with a major contractual relationship to deliver health services to a predominantly Medicaid population. We have about 28,000 members. Of these, about 27,500, or about 98 per cent are Medicaid recipients served under contract to the Michigan Department of Social Services. The balance is served under other contractual arrangements, largely with business and industrial firms. We operate two modern, well-equipped health centers in different sections of Detroit. We will soon begin the construction and operation of a new health center in a third section. This new facility, designed especially to meet the functional needs of an HMO, will increase our capacity to deliver quality health services by about 15,000.

We are a quality conscious HMO. We have a carefully managed program of quality assurance. This program is integrated with the everyday management of our health centers, operations and medical delivery systems to provide prompt and explicit guidance in matters related to quality.

We are a cost conscious HMO. Our costs on a per member, per month basis compare favorably with others delivering health care. We monitor our costs carefully and continuously, and are currently

in the process of making our cost control systems more thorough and sophisticated. We use a variation of zero-based budgeting, and in this process separate out our growth and change plans and budgets so that we may monitor them very carefully.

We are a socially conscious and socially responsible HMO. We have sought from the outset to serve all socioeconomic sectors of Detroit, and to be responsive to and accountable to them. However, we have made a special effort to bring affordable, quality health care to the medically underserved, and have a record in this regard of which we are justly proud.

We are a fiscally sound and responsible HMO. Our financial statements describe a non-profit corporation which is financially stable, and now fully capable of undertaking a major step in corporate growth: the building of a third health center without government grants for this purpose. We are living proof that a Medicaid HMO with only 2% membership in the commercial sector, can return a valid service to the people of the State and the Nation while it responds to the challenge of marketing in the commercial sector.

Finally, we have good, mutually productive relationships with the State of Michigan Department of Social Services. Regarded in contractual terms, on our part we provide health services to Medicaid enrollees which are of comparable quality if not superior in

some areas to the fee-for-service delivery system, but at a substantially lower cost. On their part, and again in contractual terms, they provide incentives to operate in a risk-based environment. In turn, we are using these funds, as I have just indicated, to provide additional capacity to serve the City of Detroit--again, including sectors of Detroit that are among the least well-served by declaration of the Congress.

However, our relationship with the State goes well beyond these mutual benefits of contract. In the historical review which follows, I will cite some of the significant assistance provided by the State of Michigan to CHSD and to other HMOs in Michigan.

AN HISTORICAL REVIEW

To be candid, there were times in our past history when I could not have spoken in such confident terms about CHSD and its future. Since this history reveals vital matters in operating an HMO with prepaid Medicaid contracts, I will review it briefly for you.

CHSD grew out of a non-profit organization planned in 1969 and incorporated in 1970 as the Model Neighborhood Comprehensive Health Programs, Inc. (MNCHP). This agency contracted with the City of Detroit to provide health services to the residents in an inner-city Model Neighborhood which were enrolled in its health plan, using Model Neighborhood funds. From a purely financial standpoint this was a desirable arrangement. We presented our costs for providing services, and we were reimbursed in full for these costs.

MNCHP decided to seek more stable funding and to expand beyond the boundaries of the original neighborhood. This brought mixed results. On the one hand MNCHP entered into an HMO-type relationship with the Michigan Department of Social Services to provide health services as a Medicaid contractor, a relationship which continues through Comprehensive Health Services of Detroit at the present time. It also led to the purchase of a new health center outside the Model Neighborhood, and a much needed boost in serving capacity. Finally, it led to the formation of a new corporation, CHSD.

On the other hand, it led ultimately to the loss of the contract with the City of Detroit and the loss of two thirds of MNCHP membership. It also led to the loss of our major health center site provided by the City.

Let me pause in this narrative long enough to notice that without the help of the State of Michigan Department of Social Services in setting up the initial Medicaid contract, MNCHP would have eventually ceased to exist and CHSD would not have come into existence at all. We consider ourselves fortunate to be located in a state which very early took a progressive position on the development of HMOs as a means of bringing cost effective care to its Medicaid recipients.

The early years of CHSD, from 1972 to the end of 1975, can be summed up in one word: scary. An HMO which is below the breakeven

point in membership creates huge debts very, very quickly. If this situation is compounded by adverse capitation rates, as was initially the case, mounting concern gives way to pure terror. Some months we lost $150,000. During one period losses averaged about $90,000 a month.

I can assure you that the position was excruciating. Of course, we were committed to providing comprehensive, quality services to our members and we did so. We had also assembled a very qualified staff which required payment, and we met our payrolls. However, the pool of cash to honor these commitments was so pitifully small that at times using a postage stamp took on the proportions of a major management decision. It is fashionable in management circles these days to talk in terms of risk management concepts. Believe me, we could have written the book on the management of corporate anxiety. We were an organization only in a very precarious sense.

For any HMO management in these circumstances the issue is not one of worrying about the mix of membership. Rather the problem is a matter of survival with any mix of membership.

We did what had to be done. Temporarily we moved into cramped quarters in the old Model Neighborhood so that we could be in a position to service the Medicaid members in that area. In December, 1974 we acquired a motel-hotel in the New Center area of Detroit, near the General Motors and Fisher Buildings and converted the

majority of space into health center operations. This greatly increased the enrollment potential of CHSD.

We obtained a planning grant under PL 93-222 in June, 1975, and with these funds began the process of re-organizing our entire operation.

Accelerated marketing efforts brought our enrollment to the breakeven point of 22,000 in August of 1975.

We initiated discussions with the State relative to the capitation rate. After discussion with CHSD and other HMOs, and analysis of its methods of calculating allowable costs, the State agreed to recompute its capitation for 1973 and 1974. It also made an interim settlement for 1975 based upon the first six months of 1975. This settlement, combined with the higher enrollment, permitted CHSD to liquidate its indebtedness. By the end of 1975 we had achieved financial stability.

Throughout this difficult period from 1973 to 1975 the State of Michigan Department of Social Services had the foresight to develop contractual relationships which did not penalize HMOs, and provided incentives and assistance in developing effective cost controls. It also assisted us in marketing to Medicaid populations. Ultimately the State benefited by this farsighted policy.

The passage of the State HMO enabling legislation (Act 264, P.A. 1974) required CHSD to reorganize under the provision of this act. We were granted a license under the provisions of this act in December, 1975. Under the terms of this license we were not allowed to market outside of the Medicaid sector until we had completed planning and development activities relative to entry into the private health care market, and such entry was approved by the Commissioner of Insurance and Director of the Michigan Department of Public Health. (These restrictions were lifted in April, 1978.)

In the spring of 1977 we received an Initial Development Grant from DHEW to complete the planning and development activities which had been initiated in 1975 under the Planning Grant. Completion of these activities was a requisite for Federal Qualification, which we received in October, 1979. With Federal Qualification we were required to convert from a cost reimbursement contract to a full risk contract. This new contract became effective January 1, 1980.

Prior to 1980 CHSD operated under a contract which provided for reimbursement of allowable costs up to, but not to exceed, the amount per member that it cost the State in the fee-for-service world for a similar Medicaid age-sex cohort. In addition, any savings that were made (that is, any amount saved between our costs and the fee-for-service costs) were divided by formula between the State and ourselves. We split the first 20% of the savings equally; we acquired 60% and the State 40% of the balance. From 1973 through 1976 the State's portion of the cost savings was in excess of

$5,000,000. When the cost settlement for 1977 through 1979 is made, we expect the cost saving will also be of significant proportions.

Beginning in 1980 under the full risk contract, we received a prospective capitation rate, based on 90% of fee-for-service expenditures of the previous year for a similar population, plus an inflationary factor. There are no year-end cost settlement provisions. All losses are to be absorbed by the Plan, and all revenues in excess of expenses are to be retained fully by CHSD.

Our efforts to diversify our membership, while intensive, are only slowly beginning to pay off. We, along with other HMOs, suffer from the relatively low rates of penetration of HMOs nationally. As everyone knows, the Detroit economy is in terrible shape. One might think that this would lead to a quickening of interest in HMOs, but it does not seem to have had this effect.

There are other circumstances which are peculiar to Detroit which influence our rate of penetration of the commercial market. Some of these have been delineated in a DHSS publication entitled, "Case Study Report on the Competitive Impact of HMOs in Detroit." This independent study cites uncooperative employers and non-supportive labor unions as major factors in retarding growth. Uncooperativeness of unions in a union-dominated city is a severe handicap to overcome.

However, there are still more subtle factors which affect an HMO with a large Medicaid population which do not affect Detroit HMOs without Medicaid enrollment. Our own investigations of the marketplace show that such an HMO has an unjustified, negative image, or stigma to overcome. The harsh reality is that an HMO with a large Medicaid population gets unfairly stereotyped as providing inferior quality of care. Accordingly, we have an image problem to overcome among those who hold this unfortunate and false stereotype.

It is perhaps a difficult thing for the Congress to acknowledge the reality and importance of this unfortunate prejudice, but I assure you it is there and it is important. It is a cruel irony that those who choose not to market to Medicaid populations and to the underserved escape the problem, while those who do accept the challenge and responsibility suffer greatly for it.

SOME LESSONS FROM THIS EXPERIENCE

What can be learned from this experience and history which might be useful in shaping the legislation before you?

First and foremost even a small HMO is a complex organization. It is difficult to form. It is difficult to operate. It is difficult to expand and change.

Certainly our experience is consistent with that of the industry in this regard. Where states put up roadblocks or do not take

an initiative in forming HMOs, overall development lags and individual development is protracted. In a state like Michigan which takes a progressive position, the complex problems of development are facilitated.

During the development period itself, there are extended periods during which the continued existence of the HMO may be in serious question. During these periods the attention of management must be focused on internal problems of organizational development and survival--not on problems of expansion as such, and certainly not on problems of mixture. During this focus on internal problems, it is extraordinarily useful to have a state agency which truly understands these problems and helps to solve them and which does not complicate matters by providing a hostile external environment. It takes careful, prudent management to get an HMO through this period, and it takes capital.

If an organization begins, as we did, with a true organization-forming problem in the inner-city , it takes years of dedicated, careful, competent management to reach a point where bold steps to grow and diversify membership are prudent business decisions.

Secondly, each HMO is a unique enterprise and must be managed and regulated as such. It is a serious mistake to assume that the unity of the label "HMO" corresponds to a single, homogeneous entity. We develop out of different organizational histories. We are formed for different reasons, from different philosophical and ethi-

cal vantagepoints. We have vastly different demographics. We operate in much different competitive environments. We have a different relationship to influential community forces, such as labor unions, governments, banks, hospitals, etc. We are at different points in organizational development and maturity and we take different times to get to these points. Even one and the same HMO is subject to remarkable variation in time with respect to its outstanding problems.

Given the variation in HMOs, I caution against an inflexible regulatory atmosphere such as that represented in the 50-50 mix requirement, (Section 1903 (m)(2)(A)(ii) as the Social Security Act) or even a 75-25 requirement as some legislation before the Congress proposes. Such a requirement without clear waiver powers for the Secretary of HHS based upon the socioeconomic and demographics applicable to the stipulated geographical area can clearly induce poor business decisions to be in compliance on the one hand, or produce senseless regulatory casualties for non-compliance on the other.

This particular requirement was a legislative response to the fraudulent marketing practices and mismanagement found in many California-based prepaid health plans, then participating in the California Medi-Cal Program. California took aggressive action to correct the problems. They have been addressed and solved in the main. I believe the lessons learned are to the benefit of all who are involved in state contracts with HMOs. The State of California

has been and still is the clear leader in the HMO movement in this country. CHSD is living proof that an HMO which serves a predominately Medicaid population can provide a valid and valuable service, which is carefully and responsibly managed. We are moving steadily toward diversification. There is no magic in this. We have been committed to diversification from the beginning philosophically and as a posture of sound management. As a practical matter a diversified HMO is likely to be more sound financially.

Thirdly, and related to the above points, be careful in matters of timing and time-tables. Provide adequate flexibility in timing. Inflexible time schedules written into law or administrative regulations are too insensitive to the timing requirements of HMOs.

One of the reasons for the complexity of HMO management alluded to above, and for the uniqueness of HMO management problems just referred to can be meaningfully thought of in terms of the need for good timing or the coordination of different phases of HMO organization. Changes in market size and composition must be well-coordinated with changes in the capacity to deliver services. Without good timing of its diverse operations, an HMO may easily founder. If you expand membership too fast without the ability to deliver the services called for by contract, the cost of fulfilling the contract can and probably will, kill you. If you expand capacity too fast, without the members to use that capacity, then the

overhead can, and probably will, kill you. I implore you to let those who must take the risks involved make the timing decisions.

Fourthly, build in adequate incentives. HMOs are not magical problem-solvers. They work where there is adequate incentive to make them work. That is, if you reward cost-consciousness, quality-consciousness, consciousness of social equity, you will get those features in HMOs. Remove the incentive and you destroy not only the HMO idea, but the economic viability of real, valid delivery systems which take years to develop.

In Michigan the Department of Social Services understands the importance of incentives, and it manages its Medicaid contracts from this perspective. I am delighted to acknowledge its contribution to CHSD and to other HMOs in Michigan.

I would like to make more specific recommendations with respect to the fifty-fifty mix requirement. I do not question the legislative intent of this portion of the Social Security Act. What I question is the wisdom of trying to achieve this intent through the use of fixed, nationally imposed ratios. The rigid features of the law if not eliminated entirely, threaten to withdraw valid, cost-effective services from the very persons the law is intended to help. In the case of CHSD this means withdrawing services from about 28,000 persons, and at the same time destroying an organization which has demonstrated that it lives up to the ideals of federal policy.

More direct and specific methods of assuring valid, cost-effective health care for Medicaid recipients are already available in the HMO legislation and in the regulations to implement the law. These directly prescribe for selected aspects of quality care, such as the comprehensivenes in scope of the basic benefits and services, the accessibility of care, the continuity and economy of care, to note only a few. Moreover, the rules and regulations call for a number of organizational mechanisms to assure that the HMO is directly addressing quality dimensions.

Our experience and convictions lead to the recommendation that the regulation in reference be eliminated altogether. There should be no fixed and totally arbitrary ratio which serves as a criterion for deciding whether Medicaid HMOs live or die. If any criterion is to be specified, flexibility in its application should be provided. This can be accomplished by:

1. permitting a variable and negotiated percentage mix based on the socioeconomic and demographic mix of the area in question, economic conditions, the proportion of the needy and underserved in the population of the area, and the local market realities;
2. a longer and more flexible time period for achieving such negotiated variable percentage mixes;
3. a greater role for the State Medicaid contracting agency in negotiating, monitoring and modifying such requirements; and,

4. discretionary power vested in the Secretary of The Department of Health and Human Services to waive requirements for cause and where the basic intent of the legislation is not served.

In closing, let me say that in the day-to-day running of an HMO, I run into issues of cost, issues of quality, issues of social equity and responsibility. No one of these should be faced as if a wall separates it from the others. The difficulty of the health management decisions I make is that these issues are so profoundly tied together, that they cannot be solved on a piecemeal basis.

I suppose the same problem occurs in wise federal health policy. You must balance and integrate matters of cost, quality and social equity. I hope that in the determination of federal policy the remarkable record of a small inner-city HMO may be of some help in the intricate equation which health policy involves.

Again, I thank the Chairman and the Sub-committee members for providing the opportunity to share our experience with you.

Senator DURENBERGER. Our final witness is Dr. Paul M. Ellwood, Jr., president, Interstudy, Excelsior, Minn.

Paul.

STATEMENT OF DR. PAUL M. ELLWOOD, PRESIDENT, INTERSTUDY, EXCELSIOR, MINN.

Dr. ELLWOOD. Mr. Chairman, I admire your patience today.

Senator DURENBERGER. Well, I am a little tired, but this is all very interesting and exciting, and you add to the interest and excitement.

Dr. ELLWOOD. My statement today presents several opinions. The first is that if we are going to rely on incentives and consumer choices rather than regulation, to reform medicare and to salvage the trust fund, we are going to have to get on with it very soon.

The second point is that more sophisticated per capita reimbursement arrangements are going to be necessary. As a number of previous witnesses have pointed out, we are going to have to adjust for health status.

I also feel we are going to have to adjust for general inflation trends in the economy. We are not going to be able to allow medical care prices to drive up the capitation rate in and of themselves.

Finally, I would like to make a point that the entire medicare program is going to have to be placed under an overall budget which is indexed to inflation within 5 years.

We suggest in our testimony, some staging of this process.

Now, on the first point about timing. With the elimination of health planning and PSRO, not even a theoretical basis for health cost containment remains for medicare.

Furthermore, the Government has weakened its position vis-a-vis providers, in providing any sort of incentive for us to get on with installing means of cost containment.

The credible threats that the Government has had are gone. As I view it, and as our actuaries view it, this program can only go on to fund depletion, the fund depletion that is forecast by the trustees, somewhere between 1989 and 1995.

There is all kind of speculation involved in the trustees' numbers, but it is pretty clear the way costs are rising in this program, there is not going to be enough money to pay the bills.

Now I say we have to begin implementing this kind of—if we intend to use this method to contain cost, we have to get on with it soon, because changing the health system is such a slow process.

You know what we have been through in Minnesota in attempting to do this. If the current market conditions prevail that exist throughout the country, our forecast, Interstudy's forecasts are that only 36 million people will be in HMO-like organizations in 1990.

Now there are 30 million people on medicare alone so that some sort of wider array of choices, prepaid choices are going to have to be made available to people on medicare if this thing is going to touch the medicare program along.

I agree with the kind of inclusion of insurers that Mr. Burdge suggested here today and you have suggested in previous legislation.

I think Senator Heinz' broadened definition of competitive medical plans will help that process.

If those things are done, it seems to me that it is feasible to have a capacity to serve up to 30 million people on medicare before the trust fund goes under or by 1992.

Now, there is another factor that slows this thing down and that is the speed with which people particularly in this age group can accept the idea of joining one of these plans.

Again, citing the Twin Cities' example, even though we have had 80 percent of our physicians in all of our hospitals offering a prepaid choice to people, we have had that for 5 years and we are still up to only 25 percent of the population.

It is just in the last year that 100,000 or more people are joining per year. It will take a long time for people to get used to this idea, to trust it, and to join it. So that even though we get the health system changed, the chances of people enrolling in it and medicare beginning to save money are at distant points.

Now, furthermore, the business of changing the medicare itself is going to be a lengthy process. You heard alluded to here today the problems, the administrative problems that have been experienced in trying to install this program.

Now, it is a pretty simple dilemma. Medicare, these experiments involve one-tenth of 1 percent of the people that medicare is responsible for. You can't overhaul a great big machine like medicare is for these kinds of short-lived activities.

Now this idea, though, of capitating medicare has now been before this committee for 11 years. It is indicative, I think, that it is actually harder to change the public system of financing than it is the private system of financing of health care.

Now, my next point is we must change the medicare reimbursement methods. I agree completely with previous witnesses that in adjusting to the age of the people that join these plans and where they live, we have to come up with some sort of a mechanism for adjusting for their health status.

We won't come up with that mechanism until we begin trying to do it on some basis other than the way we are trying to do it now.

It is obvious that someone over 65 who is sick, who is confronted with the possibility of changing doctors on an experimental basis, is going to be very, very reluctant to do it unless they are in a situation like Marshfield where you simply continue to go to the Marshfield Clinic on a prepaid basis and where the clinic assures people that they are going to continue to be covered.

Now, my last point is that we have to index this capitation rate for inflation as well. The medicare component or the medical care component of the CPI has until the last year or two until OPEC came along and high interest rates, has consistently run ahead of the CPI.

If we simply go on adjusting it for medical care prices, the forecast trust fund deficit may be delayed a little bit, but it will still come, because medical care just keeps consuming a greater and greater proportion of the consumer, of the GNP.

In fact, if we don't index the entire medicare program to some general inflation factor within 5 years, that will happen.

Now the most serious criticisms of the proposals to somehow shift medicare to a completely choice type program is that, how do you phase it. How do you suddenly or slowly even, go from one kind of a program to another?

My testimony, written testimony, contained some suggestions for that. But I think the first step is to begin capitating on a choice basis. But then I think we are going to have to begin to doing it on a community-by-community basis, perhaps when more than half of the doctors are available to people on medicare on a capitated choice basis, then that whole medicare system will have to go over to a choice basis.

Just in preparing for this testimony, I tested the real reality of that kind of a proposal. Already, over in 24 communities in this country, over 40 percent of the doctors are available on some sort of a choice basis to employed populations.

Finally, we are going to reach the point where we are going to have to do it with the whole program.

That concludes my remarks, Mr. Chairman.

Senator DURENBERGER. Thank you.

I asked a couple of the witnesses about the impact of all that competition in cities on the success of the HCFA demonstration out there.

Would you comment on that particular point, and any relationships to draw?

Dr. ELLWOOD. Yes. The Twin Cities demonstration, first of all, is a year behind in starting to these other demonstrations. There are 6,000 people now that belong to HMO's from medicare.

One of the HMO's had a year's head start. It has about 5,000 members. But one of the things that happened with the Twin Cities demonstration is that the rest of the health system decided to compete back.

So, we have very aggressive marketing going on from the physicians' health plan and other organizations that decided not to participate in this thing.

I think it is a nice indication that even the presence of this demonstration is beginning to affect the whole marketplace.

After all, people are being given choices. They are feeling the choices that the HMO's are offering aren't necessarily better than what other people are offering.

Senator DURENBERGER. I thought I heard Dr. YaDeau say he couldn't compete back.

Dr. ELLWOOD. I beg your pardon?

Senator DURENBERGER. Didn't I hear Dr. YaDeau say that he wasn't able to compete back against the demonstration?

Dr. ELLWOOD. Dr. YaDeau felt that in the case of his hospital that they ought to join the demonstration and we are delighted that they did.

Senator DURENBERGER. I see.

Let me ask one other thing related to the demonstration out there. Obviously, that one was different from the others because there were an awful lot of HMO's that could have been a part of it initially.

I think I promised Dr. Reynolds to raise this issue with you, and that is the administrative inflexibilities and some of the other

problems in the transitional phase. I would like you to talk about that briefly, and to the extent it would be helpful to us in any repetition of this experiment.

Dr. ELLWOOD. I don't think I have anything to add to what others have said. It has been a two-sided thing. The HMO's in the Twin Cities were frightened about getting into this demonstration. They felt that since they represented most of the doctors in the community, that they were going to have just exactly the kind of experience that Marshfield has had and that they would jeopardize the rest of their program by creating something that would appeal to the group of their existing patients.

In Twin Cities it isn't a matter of people switching doctors. In the case of the St. Louis Park Medical Center they did a little prior study. They found that 50 percent of their people over 65 had cancer, because they had the majority of the cancer specialists in the community working there.

So, they were frightened that they were going to be adversely selected against.

The Government, on the other hand, was equally certain that they were going to get the best possible risks and the Government was going to lose money and so on.

So, it was a 2-year bargaining thing with lots of points in favor of each side.

Senator DURENBERGER. On another issue that we have been——

Dr. ELLWOOD. I do not think it has any significance to the long-term thing other than the necessity, other than acknowledging what Dick YaDeau said that it is time to end experiments if this is what we are trying to do and get on with doing it, because the experiments just automatically create a set of artificial conditions within HICVA and within the community that in no way resemble what would happen if you really did this with a law.

Senator DURENBERGER. One of the other things we were exploring is what to do with the difference between premium revenues and costs.

I think it was Mr. Burdge, who had been talking about various kinds of rebates. Mr. Burdge also suggested that we look at investing in capital and human resource improvements, rebate premiums, retain profit and so forth.

What are your general views on that subject, including one of the issues I raised earlier, the subject of cash rebate.

Dr. ELLWOOD. Well, I agree with Mr. Burdge that the Government should set a price which it feels is reasonable to the Government. I am suggesting that that price be indexed to general inflation which will have the effect of really steadily driving down medicare price relative to what it has been before.

But then, the HMO's should be required to offer the basic benefits that the Government suggests. Then, if there is anything left over, the HMO can use that to induce more people to join the plan. It could be in the form of cash rebates or it could be for purposes of expansion.

Our problem with this business is getting more people into it. If we are going to start right out with some sort of an excess profits tax, the very things that attract new firms into a business, another firm in a business earning lots of money, are going to be lost.

So, I feel that the various adjustments that are designed to reduce the profitability of this thing are just absolutely contrary to the notion of competition.

Well, my feeling is that it is the Government's job to set a price that they regard as reasonable. It is the seller's price to deliver those services that is in a way attractive to buyers and to grow and obtain a greater and greater market share. I think that is what the free market is all about.

Senator DURENBERGER. Could that seller be an insurer or some other form of broker who combines the Government fixed benefit with some of their own and then goes and finds providers or just encourages people to go and find their own provider?

Dr. ELLWOOD. Sure. We are beginning to see now around the country, a lot of new kinds of arrangements where that exact thing is happening, what we call preferred provider organizations where insurance companies or brokers identify certain providers as more efficient than others and saying to them, "If you go to them, we will give you more coverage."

But, you are not locked into them. You can go to them if you want to. You don't have to if you don't want to. But you will get more for your money if you do.

If we are going to have plenty of innovation in this, I think we have to allow a lot of different kinds of organizations to participate.

I say, that in spite of having coined the term "HMO," it is a real problem for me. I hope you will open it up to a greater variety of insurers and organizations to deliver these services.

Senator DURENBERGER. Any other advice for us today?

Dr. ELLWOOD. Well, I guess one other point I would like to make and that is, I think you are going to be faced with a question of whether to wait for some broader competition proposal or whether to deal with something like Congressman Waxman and Senator Heinz have proposed.

My advise would be to go both ways. I think it will be a year at least before we see a comprehensive competition proposal moving through Congress.

In that period of time, if we use an indexing technique, we will have lost a year. Now that year will cost us $500 million, and furthermore, we will have lost a year, when HICVA could have been rearranging its administrative methods to take this thing on.

We can pass a measure that is much less sweeping at the outset and get most of the kinds of administrative changes and momentum that are necessary in this thing and still move on to the next stage without having one stage jeopardize the other.

I guess that is the only piece of vicarious advice I would give.

Senator DURENBERGER. Thank you very much, Paul. I appreciate your written and oral testimony, and your response to questions.

[Whereupon, at 4:45 p.m., the hearing adjourned, subject to the call of the Chair.]

[Statement follows:]

TESTIMONY before the Subcommittee on Health,
Senate Finance Committee

July 30, 1981

by Paul M. Ellwood, Jr., M.D.
President, InterStudy

I am Dr. Paul Ellwood, President of InterStudy, a nonprofit health delivery research and policy analysis group in Minneapolis. Eleven years ago, I first proposed a per-capita reimbursement approach to Medicare. InterStudy has been following the development of competitive medical plans since that time. At present, we are coordinating the Medicare capitation demonstration project in the Twin Cities. The Twin Cities is the only demonstration site involving multiple competing plans; four HMOs being offered to Medicare enrollees on a fixed capitation basis.

This committee is confronting the need to make major changes in the Medicare program if it is to survive. My statement today presents several views:

- first, if incentives and consumer choices are to be used to reform Medicare, the process must begin immediately;
- second, more sophisticated per-capita reimbursement methods are needed to reflect both the health status of people who join various plans and general inflation trends in the economy; and
- the entire Medicare program has to be placed under an overall budget which is indexed to inflation within five years, happening in several stages.

Appended to this testimony is a statement made to the Committee on Aging which presents these additional points:

- a new Medicare system based on consumer choice will result in better benefits, reduced costs, and more convenience for beneficiaries;
- a wider variety of competitive plans must be encouraged to form if Medicare beneficiaries nationwide are to have access to them; and
- an added benefit of these proposed Medicare changes will be earlier attempts to address the potentially huge problems posed by the long-term care system.

MAGNITUDE OF CHANGE REQUIRED

Consumer choices among competing alternative plans, per-capita payments, and indexed budgeting of the entire Medicare program must be instituted within the next nine months if the forecast depletion of the Hospital Insurance

Trust Fund is to be avoided. This time schedule would allow a ten-year lead time for a new Medicare system to be installed and begin to generate savings to offset the projected losses the current system will accumulate. My estimate of the long lead time required is based on InterStudy's continued analysis of the interrelationships between rates of health system change and consumer acceptance of new systems. The urgency behind the needed changes is clear. Under various sets of assumptions made by the Administration, the Trust Fund could be depleted sometime between 1989 and 2000 (see Table 1).

Table 1

Estimated Operations of the Hospital Insurance Trust Fund Under Alternative Sets of Assumptions[1]

	ALTERNATIVE I		ALTERNATIVE IIA		ALTERNATIVE III	
Calendar Year	Total Disbursements	Fund at End of Yr.	Total Disbursements	Fund at End of Yr.	Total Disbursements	Fund at End of Yr.
1985	49.5	48.4	51.6	40.6	60.2	31.1
1986	55.5	59.3	58.8	47.0	72.0	29.3
1987	61.6	69.4	66.8	51.0	85.6	21.0
1988	67.2	78.0	75.2	51.3	101.3	3.6
1989	73.8	85.3	83.5	47.9	118.8	fund depleted
1990	80.3	90.4	93.0	39.3		
1991	87.5	92.5	103.4	24.3		
1992	95.4	91.2	114.9	1.6		
1993	104.0	85.7	127.6	fund depleted		
1994	112.4	76.3				
1995	121.3	62.6				

[1] 1981 Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund

Time is running out on our opportunity to make an orderly transition to a new system. The growing alarm and turmoil that pervades the Medicaid program as a result of federal cutbacks are indicative of similar problems the elderly will face if precipitous cost-cutting actions become necessary in Medicare.

A new Medicare system in which beneficiaries are encouraged to choose more efficient sources of care would help to brake cost escalation. But moving the entire program to an inflation-indexed budget will be necessary for the government to plan and control its expenditures to avoid Medicare fund depletion.

RATE OF HEALTH SYSTEM CHANGE

The process of implementing a new system must begin soon, because changing the structure and incentives in the massive health industry is such a slow process. The following table presents forecasts for nationwide HMO enrollment under various assumptions.

Table 2

Actual HMO Enrollment Growth (1977-1980)	
Year	Annual % Increase
1977-1978	16.2%
1978-1979	11.9%
1979-1980	12.0%
Projected HMO Enrollment Growth by 1990	
Assumed Rate of Increase	Number of Enrollees
10%	22.9 million
15%	35.6 million
20%	54.2 million

If current market conditions prevail, InterStudy predicts that 36 million people will be enrolled in HMO-like plans by 1990. If, however, the definition of "HMOs" was broadened to include a wider array of price-competitive medical plans (CMPs), including insurers who are willing to accept Medicare enrollees on a prepaid, per-capita payment basis, those numbers would change dramatically. A competitive health system built around such CMPs would have the capacity to serve up to 30 million additional Medicare beneficiaries by 1992.

Another important factor determining how quickly -- or slowly -- health systems change is the rate at which consumers accept new forms of medical plans. Some time is required for consumers to enroll in new plans after they have been made available. The "take-off" period varies from community to community, and seems to be positively influenced by large numbers of physicians participating in competitive plans.

RATE OF MEDICARE CHANGES -- MORE DEMONSTRATIONS?

In my own experience, the Medicare program is harder to change than health benefit programs in private industry, and is even more resistant to change

than the health system itself. In 1970, I proposed an approach to Medicare resembling the Federal Employees Health Benefit Program. Legislation was passed in 1972 that was a distinct compromise on the original proposal; it did not pass any savings for joining HMOs or competitive medical plans on to consumers.* HCFA has had for nine years the authority to conduct experiments with the concepts of per-capita reimbursement and consumer choice in Medicare. Demonstration projects have just begun in the last year in several sites, involving so far a total of about 28,000 Medicare recipients who have chosen to enroll in plans providing services for a capitation. This represents a 0.1% sample of the total Medicare population. The following table presents the distribution of these enrollees by demonstration site.

Table 3

Total Medicare Beneficiaries in Capitation Experiments as of July 1, 1981		
Fallon, MA		5,581
Kaiser-Portland, OR		7,539
Marshfield, WI		8,554
Minneapolis-St. Paul, MN		
HMOM	147	6,108
MedCenter	504	
Nicollet-Eitel	384	
Share	5,073	
	TOTAL	27,782

The results of these demonstrations should be helpful in designing the legislation the subcommittee is considering. However, these experiments are inevitably flawed; since people over 65 are so much more vulnerable to illness, they are reluctant to disrupt their existing relationships with physicians or coverage through supplemental health insurance policies to participate in a two- or three-year demonstration project. As a result, the health status of the Medicare recipients who have chosen to participate in these demonstrations is more atypical than might have been anticipated.

*The 1972 Amendments to the Social Security Act allowed alternative reimbursement methods to be tested.

We are learning some valuable things from these demonstrations. For example, there is a clear need to adjust per-capita payments for health status. These projects are also demonstrating that prepaid plans can be very attractive to Medicare beneficiaries, through a combination of increased benefits and decreased administrative complexities from the individual's point of view. These experiments have further shown that a major overhaul of HCFA's administrative systems will be needed to allow for per-capita reimbursement on anything but a very limited scale. The need to change massive computerized eligibility and payment systems must also be factored into the lead time required to reform Medicare.

It is argued that the experience we gain with the present set of experiments will help us to design better ones, but we can't afford to wait for the perfect results since experiments of this type take five years to conduct from the proposal stage through analysis. During the five-year period of a new generation of demonstrations lasting from 1981-1986, even optimistic projections of Medicare expenditures suggest that they will increase by $43.1 billion.

CHANGING MEDICARE REIMBURSEMENT METHODS

A more sophisticated system of per-capita reimbursement must be devised than is being used in the current demonstration projects. This is necessary both to adequately compensate providers and to control costs in the new Medicare program. The new method will involve adjustments made for the health status of individual enrollees and for inflation in the economy as a whole. Ultimately, the entire Medicare program should function under a budget indexed at the general economy inflation rate.

a) Developing more equitable capitation rates

At present, Medicare capitation rates are based on the cost Medicare incurs per individual under the usual cost reimbursement system, simply adjusted by age and sex. This mechanism is not fair to either the government or health care providers. All of our experience indicates that health risk is not equally distributed across populations. The health care market is in fact broken up into segments -- some of which are based on demographics (age, sex, employment, income, education, etc.) and health status (presence of chronic illness, etc.),

and some of which are essentially created by insurance practices, legislated benefit levels, and health benefit offering methods. Insurers and providers can, either intentionally or unintentionally, further segment the market through benefit packages, premium structures, location of doctors' offices, advertising strategies, and number and type of physicians involved. (There is some evidence to suggest that different types of people are attracted to closed versus open-panel HMOs, for instance.) Efforts to discourage market segmentation in the past have been to require community rating, open enrollment, and to give the best possible comparative information to consumers. Even within those restrictions, however, segmentation can and does persist. That fact leads me to suggest that an indexed capitation rate be developed to more accurately reflect the costs of caring for individuals who join one or another health plan.

An indexed capitation rate would be adjusted as usual for age, sex, and place of residence; it should be further adjusted for the health status of the individuals enrolling in a given competitive plan. If a medical group attracted its own fee-for-service patients and thus had higher-than-average risks joining its prepaid plan, the group would receive a higher premium for those enrollees. If, on the other hand, the individuals joining plans were of better-than-average health status, the premium paid to the plans by Medicare would be adjusted downward. This health-status adjusted premium should be established for each individual at the time of enrollment. That individual would then carry that modified capitation rate for the duration of his or her enrollment in the plan.

It isn't going to be enough to adjust the capitation rate for an individual's health status and place of residence. The indexed capitation rate should also be adjusted for inflation. Inflation adjustments for Medicare should be pegged at some general index of consumer prices, such as the GNP deflator, rather than adhering to a price index strictly for medical care. The medical care component of the CPI has consistently risen faster than the overall economy and if used as the index would continue to drive up the price Medicare

pays for services. In fact, indexing the per-capita reimbursement to some general index is crucial to saving money in the new Medicare system and to saving Medicare itself. Within five years, the entire Medicare program needs to be indexed to some general inflation factor.

b) Phasing in a fully budgeted Medicare program

The most serious criticism of proposals to place Medicare entirely on a per-capita basis has been that the country is simply not ready for so massive a change all at once. A phased approach would both ensure that the options are actually in place for consumers to choose and give HCFA time to make the necessary administrative adjustments. I am proposing that Medicare be changed first on a by-community basis. Since medical care systems are local, and since they change locally, it seems logical to peg Medicare changes to those system changes rather than to age groups. The move to the new Medicare system could happen in four stages, following a chronology like this (assuming legislation passes in 1982):

- 1982 -

Phase 1: In communities where acceptable competitive medical plans exist (reflecting the broadened definition), all Medicare eligibles are immediately given the choice to enroll in a CMP or to remain covered by the old Medicare system..

Phase 2: Two years after 55% or more of a community's physicians are participating in CMPs, the entire community's Medicare system is shifted to per-capita reimbursement.*

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* This level of physician participation is not as hard to achieve as might be expected. An InterStudy survey of competitive plans in 1980 showed that in the following communities, over 40% of the physicians are already in competitive arrangements:

Appleton-Oshkosh, WI
Atlantic City, NJ
Baltimore, MD
Champaign-Urbana,Rantoul, IL
Cincinnati, OH,KY,IN
Columbus, OH
Dayton, OH
Eau Claire, WI
Eugene-Springfield, OR
Flint, MI
Green Bay, WI
Madison, WI
Milwaukee, WI
Minneapolis-St. Paul, MN-WI
Newark, NJ
Portland, OR-WA
Rockford, IL
Sacramento, CA
St. Louis, MO-IL
St. Cloud, MN
Salem, OR
Salt Lake City-Ogden, UT
San Francisco-Oakland, CA
Seattle-Everett, WA
Springfield, IL

- 1986 -

Phase 3: Beginning in the fourth year after passage of Medicare reform legislation, the entire Medicare program's budget is indexed to a general inflation rate.

- 1987 -

Phase 4: Five years after the passage of this legislation, all individuals who have just reached the age of 65 would automatically be covered under the new Medicare program.

By studying the proposed modifications in payment arrangements over this staggered period of time, the health and insurance industries would have plenty of advance warning of coming changes. The time intervals that I've chosen are realistic for most communities, particularly if health insurers decide to create CMP arrangements. Of course, health system changes will take place more slowly in some areas (chiefly rural), and exceptions to these requirements as authorized by the Secretary would need to be allowed.

The idea of budgeting and indexing Medicare to some general inflation factor has some urgency to it. Using even the Administration's optimistic assumptions, the trust fund could be in negative balance as early as 1989. Because the adjustments for inflation used in their scenario are so imprecise and the fact that savings from an indexed Medicare build over time, there will be a race between projected costs and rates of savings. Hopefully, the projected costs of the new Medicare program will intersect in time to prevent the depletion of the Medicare fund.

See attached statement submitted to the Senate Committee on Aging.

Statement submitted to the
Senate Committee on Aging

July 30, 1981

by Paul M. Ellwood, Jr., M.D.
President, InterStudy

I am Dr. Paul Ellwood, President of InterStudy, a nonprofit health delivery research and policy analysis group in Minneapolis. Eleven years ago, I first proposed a per-capita reimbursement approach to Medicare. InterStudy has been following the development of competitive medical plans since that time. At present, we are coordinating the Medicare capitation demonstration project in the Twin Cities. The Twin Cities is the only demonstration site involving multiple competing plans; four HMOs being offered to Medicare enrollees on a fixed capitation basis.

Congress is now debating changes in the Medicare program based on the installation of consumer choices and prospective per-capita reimbursement of providers. A new Medicare program would provide greater protection for senior citizens while rewarding them (through better benefits and/or lower costs) for choosing more efficient sources of care. Such a program promises significant gains for Medicare beneficiaries. The success of the new system, however, depends on making competitive medical plans widely available to beneficiaries. A new Medicare system will also afford us the opportunity to address a future problem -- the long-term care system -- at an early stage.

1. Applying market forces to Medicare will result in improved benefits and lower costs for Medicare beneficiaries. Providers and insurers who are competing to attract enrollees will have incentives to pass savings back to enrollees in the form of increased benefits and/or reductions in the costly copayments and deductibles Medicare recipients now face. Gaps in coverage, and the confusion that currently plagues Medicare as to what and how much is covered, will be alleviated. Competing plans will also be attractive to seniors if they can eliminate the need for seniors to file claims for reimbursement. The current Medicare demonstration

project in the Twin Cities is testing these hypotheses. We are finding that not only will prepaid plans compete along these dimensions, non-prepaid plans, and plans which do not have capitation contracts with Social Security, will try to offer similar advantages to their Medicare patients in order to keep them.

Predictions that a competitive system will function in this way rest on the assumption that savings can be generated to be passed back to consumers. Studies conducted by InterStudy and others indicate that efficient, high-quality health providers, whether prepaid or fee-for-service, should be able to deliver care to Medicare patients at a rate of hospitalization 20-50% less than the current average Medicare levels. The following table illustrates such reductions.

Table 1

Hospital Utilization Rates for Over 65
(adjusted data unavailable)

	Hospital Days/1000
United States (1976)	4163.7
Mayo, Olmsted County (1976)	2565.8
Marshfield Demonstration (10/80 - 5/81)	2882.5
Kaiser Portland Demonstration (1981)	1700.0
Fallon Demonstration (1981)	2700.0

Under competitive conditions, organizations will pass these savings on to Medicare beneficiaries in the form of lower premiums or added benefits. In cases where competitive medical plans are able to retain profits, their experiences will encourage more competition and lead to more choices for people on Medicare.

The Kaiser-Portland demonstration project illustrates how attractive benefits can be made if savings are passed back to Medicare enrollees:

Kaiser-Portland Demonstration

	Benefits	Charge
1)	A. Medicare benefits and B. comprehensive supplemental coverage	no charge
2)	A, B, prescription drugs, eyeglasses, and hearing aids	$6.00 a month
3)	A, B, and total dental care	$9.81 a month
4)	A, B, prescription drugs, eyeglasses, hearing aids, and total dental care	$15.81 a month

2. More and a wider variety of competitive plans will need to form if they are to be widely available to Medicare recipients. In the past, the government has focused on defining, promoting, and regulating HMOs as a model delivery system; it has not actively encouraged either insurers or providers to create a broader variety of competitive plans. One way to begin to do so would be to broaden the definition of what constitutes a competitive plan for the purpose of contracting with Medicare, as Senator Heinz has done. I would urge that the re-definition go even further. Removing the reinsurance provisions from the Heinz definition would effectively allow an even wider variety of organizational forms. A further section could be added to the definition which explicitly allows insurers to participate by paying them on a per-capita basis for those people to whom they already provide health insurance.

The way CMPs are reimbursed will clearly affect the speed with which they spread. The use of an "adjusted community rate" to control excess profits achieved by CMPs is clearly a deterrent to the formation of new types which might be very effective competitors. In my view, this mechanism represents a continuation of the very cost reimbursement philosophy that has made Medicare into such a fueling agent for medical care inflation, and such an instrument for the preservation of the status quo. If Medicare reimbursement rates are indexed for both health status and general inflation, the opportunity for plans to earn profits can only come through greater efficiency. An adjusted community rate then becomes an unnecessary safeguard.

Most health care providers and insurers have had little experience with risk arrangements for providing care to Medicare recipients. An inducement for them to enter into such arrangements might be to make cost-based reimbursement available during a predetermined start-up phase, with a bonus for those whose costs are below the indexed capitation rate.

3. The long-term care system poses potentially huge problems in the future as the population ages. Incentives for efficiency in Medicare will prompt plans to confront this problem now. Long-term care is more rigidly tied to government entitlement programs than acute care; it is already the greatest drain on state Medicaid budgets. Minnesota is cited as an example.

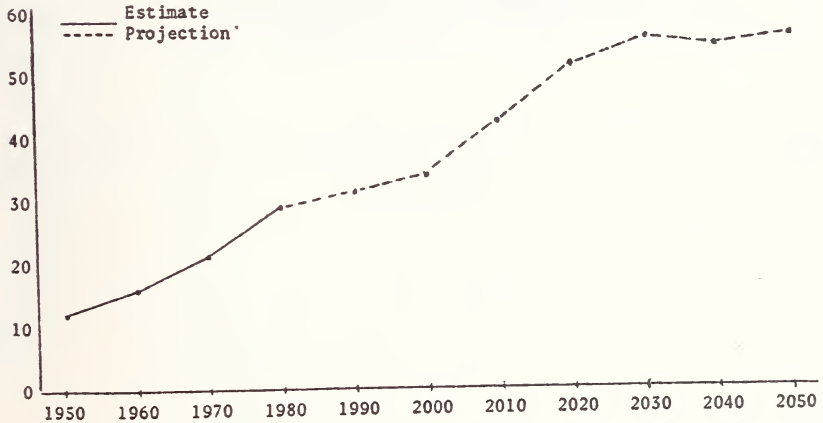
Table 2

Medicaid Long-Term Care Services

	Year	% of Medicaid Spent on Long-Term	Amount
Federal Government	FY78	41.9%	$7,583 million
State of Minnesota	FY80	71.0%	$ 402 million

The problems posed by the long-term care system can only be heightened as the proportion of older Americans rises in coming years. The number of people over 65 will approximately double by the year 2030.

Table 3: Number of Elderly in the United States: 1950-2050



Source: United States Bureau of Census

As the population ages, so will our need to find improved, efficient ways of caring for them increase.

Competitive plans under the current Medicare/capitation demonstration projects are attempting to expeditiously move patients out of the hospital and into less costly settings. In so doing, they have discovered the absence of effective long-term care programs which emphasize independence and life outside of institutions. Some innovations are already emerging from these demonstrations (which are necessarily limited precisely because they are just demonstrations), we can at least anticipate substantial improvements at the interface between long-term and acute care. A head start on this problem is essential since it has the potential to become even more serious economically than the one now facing the country with acute medical care.

[By direction of the chairman the following communications were made a part of the hearing record:]

AMERICAN CHIROPRACTIC ASSOCIATION

Executive Office
(202) 347-9090

1735 De Sales St., N. W., Suite 600, Washington, DC 20036

STATEMENT
OF THE

AMERICAN CHIROPRACTIC ASSOCIATION

TO THE

HEALTH SUBCOMMITTEE
COMMITTEE ON FINANCE
UNITED STATES SENATE

CONCERNING

COMPETITIVE HEALTH AND MEDICAL PLANS
PROVIDING MEDICARE SERVICES

JULY 30, 1981

The Congress can be justifiable proud of its leadership role in encouraging the development of competition in the health-care market. The American Chiropractic Association (ACA) is pleased to testify regarding competitive health care plans and the integration of Medicare services in the Health Maintenance Organization setting. HMOs do provide another avenue of providing quality health care to the American people. This is not to say, however, that the HMO experience with providing Medicare services has been without its flaws. Specific safeguards should be employed to assure that full compliance with Medicare's requirements are met, yet allowances for innovation are maintained. Provisions to meet these objectives should be incorporated into your consideration:

- Guaranteed basic benefits under Medicare Parts A and B should be clearly enunciated assuring that all health care practitioners covered under the law are available to Medicare patients.

- Freedom to offer additional benefits and options should be allowed.

- Catalogues advertising the services should specify the variety of services offered by each health care profession. Patients should be adequately informed of all their options including chiropractic.

- Patient freedom of choice should be mandated.

The ACA would be remiss without initially reiterating its long standing support for a competitive health care system. A true system of competition would allow the individual patient freedom of choice to choose his health care practitioner. From ACA's vantage point, it is important to start with this premise in mind because a patient's right to choose has been circumvented in a number of cases.

Certainly the HMO concept provides a dynamic thrust into the center of the traditional health care delivery system. HMOs bring into focus a viable alternative

to traditional health care delivery. Individual patients and business looking for competitive markets to offer their employees have found an alternative with HMOs. Testimony before this committee will reflect the important role that HMOs offer as we as a nation look to ways to provide quality care in a cost-conscious manner.

The federal government's interest in seeing quality health care is twofold. As a national policy we have recognized the importance of a healthy nation and made that a national priority. Additionally, in keeping with the national goal of quality health care, the federal government as the employer of tens of thousands of individuals as well as being the administrator of such programs as Medicare has a vital interest in the manner of delivery of such service and at what cost. Indeed, the obvious is that social programs individually are among the most rapidly escalating cost factors influencing our inflation and economic difficulties.

HMOs AND CONGRESS

The U. S. Congress has continued to recognize the wisdom of health maintenance organizations. This year federal assistance to HMOs was extended for three additional years.

This program of assistance and incentive to develop HMOs was reflected in the $20 million committed for FY 1982-84. An additional $1 million was allocated for technical assistance and management training. Further support via a loan fund was covered by a $5 million annual allocation as a safety net against HMO defaults. Undoubtably a great deal of discussion this year focused on the continued need to stimulate the development of HMOs and as more private concerns enter the market place the federal government may feel that further stimulation with federal dollars is not necessary.

ACCEPTANCE OF HMOs AND THEIR COMPLEXITIES

The HMO concept is a recent development in the long course of health care delivery systems. It is fair to say that organized medicine has traditionally been slow to accept new developments and reluctantly, and only recently, has it acknowledged HMOs' role in health care. There was even an effort to assert ethical violations against those professionals who affiliated with HMOs.

Once it became apparent that the concept enjoyed a certain degree of popularity organized medicine recalculated its position. The success of HMOs caused dismay because of the economic repercussions. The position of the traditional independent practitioner who worked on a fee for service basis would be jeopardized. The competition was succeeding. In any case HMOs are unquestionably medically oriented and dominated, and therefore, chiropractic's position is placed in a difficult posture in respect to its role in HMOs due to socio-economic conflicts between organized medicine and chiropractic.

Many regions around the country have heartily embraced the HMO concept. Indeed in certain communities in the West Coast, the Twin Cities (Minnesota), Urban Northeast, and Florida a sizable percentage of the market is making use of this form of health care. Employers have found it a reasonable and cost-effective form of health insurance for its employees.

HMOs occupy the position of a key stone in the development of a foundation for a new competitive health care system. Pro-competition legislation will certainly add to the emphasis on HMOs in the marketplace. States across the country are monitoring the growth of HMOs and adopting legislation to incorporate it into their health care delivery system.

HMOs AND MEDICARE

Medicare and other federal health care programs are undergoing close scrutiny as the Reagan Administration and Congress search for a handle to control the uncontrolled growth in federal health costs. Entitlements have been cut. Major changes in the federal government's role are being shaped. Changes in co-insurance, deductibles, and co-payments are being undertaken.

Among the developments that are occurring are the contracting out of Medicare recipients' care to HMOs. For a percentage such as a 95% reimbursement rate of the federal government's cost HMOs will undertake to furnish health care to these recipients. It is in this capacity that chiropractic is particularly concerned

with the services of HMOs and the posture of the federal government with the Congressional mandate on the one hand and the independent medically dominated HMOs on the other. Their goals are sometimes in conflict.

CHIROPRACTIC CARE UNDER MEDICARE IN A HMO SETTING

There is no secret of the socio-economic conflict which organized medicine and the chiropractic community have experienced. The delivery of quality health care in an economically competitive setting is a commendable goal and one which the chiropractic profession welcomes. The common denominator in the preceding two statements raises the issue at hand: What is chiropractic's role in HMOs? An examination and analysis of federal policy, experience of HMOs with Medicare, and experience in HMOs in general are informative and illustrative.

The federal policy and Congress' intent has been clear in regard to chiropractic. The United States government has followed up on the initiatives of the Congress in many respects. The Federal Government recognizes chiropractic in Medicare, Medicaid, vocational rehabilitation, Federal and Postal employees workers compensation, the federal employees health benefits program, the Health Professions Act, and in the Internal Revenue Service as a "medical" expenditure. the U.S. Department of Education has recognized the Council on Chiropractic Education as the official accrediting body for the chiropractic profession on an equal basis with other professions. The import of the foregoing list is that the intent, the mandate, by the Congress is clear: a recognition and integration of the chiropractic profession as a partner in the nation's health care system. Is this federal mandate being incorporated into Medicare coverage under HMO's auspices? The answer appears to be no.

The ACA feels that the experience to date with HMOs which have contracted to cover Medicare patients indicates a lack of freedom of choice. Rights to specific care authorized by laws governing Medicare are not being fully implemented. Specifically, chiropractic services are covered under Medicare, but HMOs under Medicare contracts have been remiss in seeing that its patients are aware of this service. And the Department of Health and Human Services has failed to enforce the Congressional provision.

Medical physician dominance over the health-services market has sought - and often successfully — to subject chiropractors to practice restrictions. This medical anti-consumer campaign restricts the supply of available health-care providers. In part, this may be the result of a "fraternal" attitude by organized medicine that does not want to allow another "fraternity" into the program. This, however, is no excuse to deny rights enunicated under the Medicare law. HMOs should not substitute its own philosophy in contradiction to the laws of the land. Nor should the Department of Health and Human Services blatantly ignore its obligations to see that Medicare beneficiaries receive the access to chiropractic care which Congress intended them to have.

HMOs AND CHIROPRACTIC IN GENERAL

The experience of HMOs generally in dealing with members of the Chiropractic profession is virtually non-existant. One positive step that was taken was the restriction that the American Medical Association placed on its members regarding the prohibition of MDs dealing professionally with Chiropractors was dropped from the AMA's code of ethics last year.

This long standing opposition to chiropractic by organized medicine has created, however, some residual affects which adversely impact upon a truly competitive market. There is still resistance among members of organized medicine to full cooperation with the chiropractic profession, and thus this resistance is reflected in medically dominated HMOs as well.

The federal government must not permit the Congressional will as to the availability of chiropractic in Medicare to be thwarted by a monopolistic and anti-competitive medical profession.

COST-EFFECTIVENESS OF CHIROPRACTIC HAS BEEN SHOWN

Worker compensation studies in over a half dozen states reflect the cost-effectiveness of chiropractic services versus medical services. These studies using

individual state's own records determined that chiropractic got workers with comparable injuries back on the job faster and at less cost than by treatment by M.D.S.

The rapidly escalating costs of providing health care are one of the major problems confronting the United States, and chiropractic is providing competitive health care in a quality manner. Case studies in California, Wisconsin, Florida, Kansas, Iowa, Montana, and Oregon reflect chiropractic cost-effectiveness. More specifically, these studies revealed that chiropractic care reduces treatment costs, reduces compensation costs, reduces employee time losses, and reduces worker disability in comparison with other types of care for the treatment of back and related neck injuries.

CONCLUSION

This committee's hearing relates directly to changes in the method of Medicare reimbursement for competitive health and medical plans. The decisions on the changes and issues addressed will have far reaching effects upon groups entering or presently serving in the health care delivery system. Competition is the hallwork of the entire American system. Competition in the health-service market is especially important. The Secretary of Health and Human Services, Richard S. Schweiker, said, only as recently as May 4, 1981, that "Competition is our highest priority in the health field." While considering this legislation we urge the committee to take notice of some of the short-comings that are developing in the services which are provided in the HMO setting.

We further urge the committee to reflect upon the nature of competition in health care today. Dr. Theodore Cooper, former Assistant Secretary of Health, HEW, at a meeting in 1977 on "Competition in the Health Care Section," said: "Where competition fits into the scheme of things is not clear...competition should come from the sector that controls the standard of living (housing, etc.) not from the health industry."

In other testimony before the 97th Congress this year the American Chiropractic Association has addressed its concerns about federal actions regarding

the need for antitrust enforcement in the health care industry. The guidelines we have suggested in this testimony will act as a check against anti-competitive practices that occur among health practitioners due to socio-economic self-interest.

While health plans should not be encumbered with restrictive government regulations, it is essential that Congressional policy objectives be maintained. Medicare recipients should not be treated as secondary citizens but should be allowed the full freedom of choice, including chiropractic, as specified by Medicare. Under the Medicare program that we envision to be offered by HMOs all services covered by Medicare would be clearly identified. Each health care practitioner (M.D., D.O., chiropractor, podiatrist, optometrist, etc.) authorized by law to offer services under Medicare would be named so that the patient could freely choose his practitioner.

The federal government would become the leader in demonstrating a truly competitive system in the health care market. Responsible choices and healthy competition will result because the health care consumer will be fully informed and freely able to choose his health care. If these notices are mandated the American people will have a program where choices are offered and anti-competitive practices are curtailed.

Testimony to U.S. Senate Committee on Finance, Subcommittee on Health
July 29, 1981 Hearing: Medicaid Prepayment Contracts

Summary:

- California has experimented with Medicaid prepayment contracts since 1971 in the form of pilot programs and regular prepaid health plans.
- The overwhelming result of 10 years experience has been that at-risk prepaid contractors can and do supply comprehensive medical services to an indigent population at a cost which is 10-20% below the cost of equivalent services paid for by a fee-for-service system.
- California has signed only four new HMO contractors since 1974. We attribute this to the requirements that Medicaid contractors be HMOs and be licensed in this state as health care service plans by Department of Corporations.
- California currently has a 4% (135,000) penetration into fee-for-service by prepaid HMO contracts. We expect that the maximum, given the number of HMOs in California, will be 8-10% (270-400,000).
- In order to expand the participation in prepayment (in terms of enrollment) California will have to contract with non-HMO at-risk contractors (fiscal intermediaries, counties, capitated primary care networks, etc.).
- Federal rules should be changed to allow States to set their own course with respect to innovations in benefits, financing and organizational type.

ENACTMENT OF FEDERAL MEDICAID LEGISLATION IN 1965 REPRESENTED THE MOST FAR-REACHING EFFORT TO ANSWER HEALTH CARE NEEDS OF LOW-INCOME INDIVIDUALS IN THE NATION'S HISTORY. ESSENTIALLY, THE FEDERAL GOVERNMENT OFFERED STATES PARTIAL FINANCIAL ASSISTANCE TO DEVELOP MEDICAL PROGRAMS FOR INDIGENTS. IN ORDER TO BENEFIT FROM WHAT APPEARED TO BE THE DESIRABLE INFLUX OF FEDERAL FUNDS FOR THIS PURPOSE, THE CALIFORNIA LEGISLATURE PASSED THIS STATE'S VERSION OF MEDICAID OR MEDI-CAL IN NOVEMBER 1965. MEDI-CAL BEGAN OPERATING IN MARCH 1966.

WITHIN A SHORT TIME CALIFORNIA'S PUBLICLY SUPPORTED HEALTH SYSTEM WAS OVER-WHELMED BY A MASSIVE INCREASE IN HEALTH CARE DEMAND COUPLED WITH SOARING COSTS TO REIMBURSE PROFESSIONALS AND INSTITUTIONS FOR THEIR SERVICES. OVERUTILIZ-ATION AND MISUTILIZATION BY BOTH BENEFICIARIES AND PROVIDERS MADE IT CLEAR THAT BASIC CHANGES WERE NEEDED. IN AN ATTEMPT TO CONSTRAIN GROWTH IN THE MEDI-CAL BUDGET, CALIFORNIA FIRST IMPOSED FEE SCHEDULES UPON PHYSICIANS AND OTHER HEALTH CARE PROVIDERS. THIS WAS FOLLOWED BY A SYSTEM-WIDE 10 PERCENT REDUCTION IN MEDI-CAL RATES OF PAYMENT. FOR VARIOUS REASONS, THESE STRATEGIES FAILED TO WORK.

POLICYMAKERS DETERMINED THAT MORE EFFECTIVE PROGRAM CONTROLS OVER MEDI-CAL ELIGIBILITY AND USE OF SERVICES BY BENEFICIARIES PLUS LOWER PROVIDER PAYMENT LEVELS WOULD ADDRESS THE PROBLEMS. A BETTER HEALTH CARE DELIVERY SYSTEM WAS DEEMED ESSENTIAL TO THE SOLUTION.

THE CONCEPT OF "AT RISK" PREPAID HEALTH CARE, THE CONCEPT UNDERLYING HMOS, ALREADY HAD GAINED CONSIDERABLE ATTENTION DURING THE YEARS PRECEDING FINAL ENACTMENT OF MEDICAID. IN FEBRUARY 1968, CALIFORNIA FUNDED THE FIRST OF FOUR

PILOT PROJECTS TO TEST THE FEASIBILITY OF A PREPAID HEALTH SYSTEM FOR THE STATE. THESE ORGANIZATIONS CALLED PREPAID HEALTH PLANS (PHPS) CONTRACTED TO PROVIDE THE FULL RANGE OF MEDI-CAL BENEFITS (WITH CERTAIN EXCEPTIONS) TO THOSE WHO ENROLLED. THE STATE PAID FOR THESE SERVICES BY CAPITATION, THAT IS, A PREDETERMINED AMOUNT EACH MONTH FOR EACH ENROLLED MEMBER.

CALIFORNIA ADMINISTRATORS AND LEGISLATORS STRUGGLED TO CHANGE MEDI-CAL DURING 1970. IN OCTOBER 1971, THE MEDI-CAL REFORM ACT BECAME LAW. KEY PROVISIONS IMPOSED STRINGENT UTILIZATION CONTROLS ON THE FEE-FOR-SERVICE SYSTEM WHILE SIMULTANEOUSLY PROMOTING PREPAID HEALTH PLANS. THE CONTROLS WERE INTENDED TO ENCOURAGE THE FORMATION OF PREPAID HEALTH PLANS BY PROVIDERS, ESPECIALLY PHYSICIANS, TO CONTRACT WITH THE STATE TO SERVE MEDI-CAL BENEFICIARIES.

IT WAS HOPED THAT PREPAID HEALTH CARE WOULD BE MORE EFFECTIVE THAN THE FEE-FOR-SERVICE SYSTEM: BENEFICIARIES WOULD BE GUARANTEED ACCESS TO CARE, GOVERNMENT INTERVENTION WOULD BE MINIMAL, AND STATE CONTRACTING THROUGH PREPAID CAPITATION WOULD ENCOURAGE THE PRACTICE OF PREVENTIVE MEDICINE AS WELL AS OPERATIONAL EFFICIENCY.

THE LEGISLATURE THEN PASSED THE WAXMAN-DUFFY PREPAID HEALTH PLAN ACT IN 1972. THIS CONSOLIDATED MANY RELATED STATUTES, ENTITLED MEDI-CAL BENEFICIARIES TO CHOOSE EITHER FEE-FOR-SERVICE OR PREPAID HEALTH CARE, AND SET FORTH OBLIGATIONS OF THE PLANS TO THOSE WHO BECAME MEMBERS. ENFORCEMENT WAS DELEGATED TO THE DEPARTMENT OF HEALTH CARE SERVICES.

THE MEDI-CAL PREPAID HEALTH PLAN (PHP) PROGRAM WAS FORMALLY INITIATED IN 1972, WITH THE CLEAR INTENT THAT IT WOULD SOON BECOME A DOMINANT MODE OF PUBLICLY FINANCED HEALTH CARE DELIVERY. INDEED, FEE-FOR-SERVICE UTILIZATION CONTROLS ESTABLISHED BY THE MEDI-CAL REFORM ACT FUNCTIONED TO THE ADVANTAGE OF PHPS. UNDER THE NEW FEE-FOR-SERVICE CONTROLS, SOME BENEFICIARIES WERE FRUSTRATED BY LIMITATIONS ON OFFICE VISITS, PRESCRIPTIONS, AND OTHER SERVICES. THERE WERE SIMILAR REACTIONS REGARDING THE NEED FOR PHYSICIANS TO SECURE PRIOR AUTHORIZATION FROM THE STATE FOR OTHER THAN ROUTINE PROCEDURES AND TREATMENTS. THERE EVEN WAS A PERIOD DURING WHICH FEE-FOR-SERVICE BENEFICIARIES WERE REQUIRED TO CO-PAY MINIMAL AMOUNTS FOR OFFICE VISITS AND PRESCRIPTIONS. PHP ENROLLEES WERE NOT EXEMPT FROM THESE LIMITATIONS.

BY THE END OF 1974, THE STATE WAS PARTY TO 54 PHP CONTRACTS WORTH NEARLY $85 MILLION PER YEAR, COVERING OVER 250,000 MEDI-CAL RECIPIENTS. THIS REPRESENTED ROUGHLY 10 PERCENT OF ALL CALIFORNIA MEDI-CAL ELIGIBLES. UNQUESTIONABLY, THIS THREE-YEAR PERIOD REFLECTED DRAMATIC ADVANCES IN STATE CONTRACTING FOR PREPAID HEALTH CARE. UNFORTUNATELY, SERIOUS DEFICIENCIES ALSO EMERGED.

CONTRACTS WERE APPROVED, AND A STATE APPARATUS WAS CREATED TO MONITOR THE PERFORMANCE OF THESE PLANS. HOWEVER, THE ENTIRE EFFORT WAS SOON PLAGUED BY CHARGES OF POOR MEDICAL SERVICE, INAPPROPRIATE CONTRACT AWARDS, AND A GENERAL STATE FAILURE TO ENFORCE LEGAL REQUIREMENTS. THIS LED TO WIDELY PUBLICIZED STATE LEGISLATIVE AND CONGRESSIONAL HEARINGS. THE CONSEQUENCE WAS A DAMPENING OF CALIFORNIA'S ENCOURAGEMENT OF MEDI-CAL PHPS WHICH HAD BEEN SO AGGRESSIVELY SPONSORED UNDER THE EARLIER ADMINISTRATION.

CALIFORNIA'S LEGISLATIVE REACTION TO THE PROBLEMS IN THE PROGRAM WAS TO BROADEN ITS REGULATORY BASE BY INVOLVING ANOTHER AGENCY AND BY INSTITUTING STRICT PERFORMANCE CRITERIA FOR HEALTH PLANS. UNTIL 1975 PREPAID HEALTH PLANS (PHPS) WERE REGULATED UNDER THE PROVISIONS OF THE KNOX-MILLS HEALTH PLAN ACT OF 1965 AND THE WAXMAN-DUFFY PREPAID HEALTH PLAN ACT OF 1972. KNOX-MILLS REQUIRED ALL HEALTH CARE SERVICE PLANS TO REGISTER WITH THE CALIFORNIA ATTORNEY GENERAL, WHO, THOUGH MINIMALLY STAFFED, WAS RESPONSIBLE FOR ENFORCING VARIOUS STATUTES GOVERNING THE ACTIVITIES OF THESE PLANS.

FOLLOWING THE NUMEROUS DISCLOSURES OF SHORTCOMINGS IN PHP MARKETING PRACTICES, CORPORATE BEHAVIOR AND SERVICE DELIVERY, THE LEGISLATURE ENACTED THE KNOX-KEENE HEALTH CARE SERVICE PLAN ACT OF 1975. THIS LAW TRANSFERRED TO THE CALIFORNIA COMMISSIONER OF CORPORATIONS ON JULY 1, 1976 THE REGULATORY FUNCTIONS PREVIOUSLY VESTED IN THE ATTORNEY GENERAL. IN ADDITION, THE ACT IMPOSED MORE RIGOROUS STANDARDS ON HEALTH PLAN ACTIVITIES. THE COMMISSIONER'S NEW RESPONSIBILITIES INCLUDED LICENSING, AUDITING, AND ESTABLISHING RULES OF ETHICAL CONDUCT FOR THE PLANS.

IN 1976, THE STATE ASSEMBLY SPECIAL SUBCOMMITTEE ON HEALTH CARE INVESTIGATIONS CONDUCTED HEARINGS WHICH ALLEGED FURTHER IMPROPRIETIES IN PHP MANAGEMENT AND STATE REGULATION BY THE CALIFORNIA DEPARTMENT OF HEALTH. SOON AFTERWARD, THE DEPARTMENT OF HEALTH REQUIRED ALL MEDI-CAL PHPS TO BECOME QUALIFIED AS HMOS UNDER THE RECENT FEDERAL LEGISLATION WHICH RESTRICTED FFP TO A CERTAIN SET OF QUALIFIED CONTRACTORS. THIS RESULTED IN A RAPID REDUCTION IN BOTH THE NUMBER OF PHPS HOLDING MEDI-CAL CONTRACTS AND THE NUMBER OF BENEFICIARIES SERVED.

WHEN THE STATE LEGISLATURE PASSED THE KNOX-KEENE HEALTH CARE SERVICE PLAN ACT AND THE FEDERAL GOVERNMENT PUT RESTRICTIONS ON MEDICAID CONTRACT EXPENDITURES BY REQUIRING PHPS TO BE HMOS, DEVELOPMENT OF CALIFORNIA'S MEDI-CAL PHP PROGRAM DRIED UP. NOT ONLY WAS NEW PLAN INTEREST NONEXISTENT, BUT MANY EXISTING CONTRACTORS CLOSED THEIR DOORS. BETWEEN JANUARY 1975 AND JANUARY 1977, 75% OF THE PHP PROGRAM CONTRACTORS WERE LOST ALONG WITH 50% OF THE ENROLLMENT. SINCE 1974 ONLY 4 NEW PHP CONTRACTS HAVE BEEN SIGNED. OF THE 20 HMOS OPERATING IN CALIFORNIA ONLY ELEVEN ARE UNDER CONTRACT WITH THE STATE TO PROVIDE MEDI-CAL SERVICE.

THE STATE'S GOAL FOR ENROLLMENT IN ORGANIZED HEALTH SYSTEMS, BY THE CLOSE OF FISCAL YEAR 1982-83 IS 400,000. IN THE DEPARTMENT'S ESTIMATION SUCH PROGRAM GROWTH WILL SIMPLY NOT BE POSSIBLE THROUGH PHPS ALONE. PLANS UNDER CONTRACT AT PRESENT HAVE A MAXIMUM CONTRACTUAL POTENTIAL OF 270,000 MEMBERS (THE DEPARTMENT IS CONFIDENT THAT THE CURRENT CONTRACTORS COULD ADEQUATELY SERVICE THIS NUMBER OF MEMBERS). QUITE FRANKLY WE NEVER EXPECT THIS LEVEL TO BE APPROACHED GIVEN CURRENT GROWTH RATES AND PROGRAM STANDARDS.

IN ORDER FOR THE PHP PROGRAM TO CONTRIBUTE MORE THAN THE 133,000 MEMBERS TOWARD THE 400,000 GOAL, SEVERAL OBJECTIVES MUST BE MET:

A. INCREASED PARTICIPATION OF LICENSED AND FEDERALLY QUALIFIED HMOS IN THE PHP PROGRAM. THERE ARE 20 FULL-SERVICE HMOS LICENSED BY KNOX-KEENE--11 OF THESE ARE CURRENTLY UNDER CONTRACT WITH DHS AS PHPS. PARTICIPATION BY THE REMAINING 9 COULD POSSIBLY BOLSTER THE GROWTH TO A LEVEL OF AROUND 250,000.

B. BENEFICIARIES MUST BE GIVEN INCENTIVES TO ENROLL. ENROLLMENT WILL NEVER BURGEON UNTIL THE PHP OPTION IS MORE ATTRACTIVE THAN FEE-FOR-SERVICE MEDI-CAL. MONETARY INCENTIVES WOULD BE THE MOST ATTRACTIVE BUT AN EXPANDED SCOPE OF BENEFITS FOR PHP MEMBERS MIGHT ALSO CAUSE ELIGIBLES TO OPT FOR THE PHP OPTION.

C. A DUAL CHOICE EFFORT MUST BE ADEQUATELY STAFFED, FUNDED AND SUPPORTED BY THE STATE AND, MORE IMPORTANTLY, THE COUNTIES IN ORDER TO CATCH POTENTIAL MEMBERS AT THE ELIGIBILITY INTAKE POINT. THEN THE POTENTIAL MEMBER SHOULD BE URGED TO CHOOSE THE COST EFFECTIVE ALTERNATIVE (HMO MEMBERSHIP).

IF ALL THESE OBJECTIVES WERE MET, IT IS ESTIMATED THAT PHPS COULD POTENTIALLY GENERATE A TOTAL OF 250,000 - 300,000 MEMBERS. HOWEVER, IF CURRENT STANDARDS ARE MAINTAINED AND THE NUMBER OF CONTRACTS STAYS THE SAME IT IS ESTIMATED THAT PHPS WILL NEVER SHOW MORE THAN 150,000 - 200,000 MEMBERS.

THIS FIGURE LEAVES US 200,000 - 250,000 SHORT OF OUR 400,000 GOAL. TO CONVERT SUCH A LARGE NUMBER OF ENROLLMENTS WE MUST RELY ON LARGE SCALE PILOT PROGRAMS AND OTHER NON-HMO ORGANIZED HEALTH SYSTEMS.

TWO CURRENTLY SUCCESSFUL NON-HMO CONTRACTORS ARE CALIFORNIA DENTAL SERVICE AND REDWOOD HEALTH FOUNDATION.

CALIFORNIA DENTAL SERVICE (CDS)

THIS PROGRAM IS DESIGNED TO IMPROVE THE QUALITY OF DENTAL SERVICES RENDERED TO MEDI-CAL BENEFICIARIES AND TO ENCOURAGE THE DEVELOPMENT OF A MORE EFFICIENT DELIVERY OF THESE SERVICES. AN ADDITIONAL OBJECTIVE IS THE LONG-RANGE REDUCTION OF COSTS THROUGH PREVENTIVE DENTAL CARE AND EDUCATION, PARTICULARLY WITH REGARD TO CHILDREN'S SERVICES. THIS PROGRAM IS ALSO TESTING THE FEASIBILITY OF A SINGLE ORGANIZATION PAYING FOR SPECIFIC HEALTH CARE SERVICES PROVIDED TO ALL MEDI-CAL RECIPIENTS FOR A PREDETERMINED RISK PAYMENT PER RECIPIENT.

CALIFORNIA DENTAL SERVICES HAS CONTRACTED TO PAY FOR AUTHORIZED DENTAL SERVICES ON A STATEWIDE BASIS TO MEDI-CAL RECIPIENTS THROUGH A RISK CONTRACT SHARED BY APPROXIMATELY 12,000 MEMBER DENTISTS. ENROLLEES OF PREPAID HEALTH PLANS AND PERSONS COVERED UNDER OTHER PILOT PROGRAMS PROVIDING DENTAL SERVICES ARE NOT INCLUDED IN THE PROGRAM. ALL OTHER MEDI-CAL RECIPIENTS (APPROXIMATELY 2,800,000) MAY RECEIVE THE FULL RANGE OF MEDI-CAL DENTAL SERVICES FROM ANY DENTAL PROVIDER WHO HAS NOT BEEN SPECIFICALLY EXCLUDED FROM MEDI-CAL PARTICIPATION BY THE DEPARTMENT.

CALIFORNIA DENTAL SERVICES FURNISHES INDIVIDUAL PROVIDER INFORMATION, ADVICE, AND INSTRUCTIONS CONCERNING THE EXTENT AND LIMITATION OF SERVICES. IT ISSUES PAYMENT FOR ALL VALID CLAIMS FOR COVERED SERVICES RENDERED TO MEDI-CAL RECIPIENTS. IT ALSO OPERATES A QUALITY-OF-CARE CONTROL PROGRAM USING PRIOR AUTHORIZATION FOR CERTAIN DENTAL SERVICES AND REVIEW OF COMPLETED TREATMENT FORMS.

AN IMPORTANT ASPECT OF THIS PROGRAM IS THE SHARING OF THE MONETARY RISKS BETWEEN THE MEMBER DENTISTS PROVIDING SERVICES AND CDS. ANY COST OVERRUNS IN

THE PROVISION OF SERVICES WILL BE BORNE BY THE PARTICIPATING PROVIDERS FOR THE FIRST FIVE PERCENT AND CDS FOR ANY AMOUNTS THEREAFTER. ALL GAINS GREATER THAN FIVE PERCENT OF THE CAPITATION PAYMENTS WILL BE RETURNED TO THE STATE.

THE PILOT PROGRAM WAS EVALUATED. IT WAS DETERMINED THAT IN ORDER TO COMPLY WITH LEGAL REQUIREMENTS THE DEPARTMENT SHOULD SEEK, THROUGH A COMPETITIVE BID PROCESS, A SUITABLE DENTAL FISCAL INTERMEDIARY AT-RISK CONTRACTOR. THE DEPARTMENT INITIATED A DENTAL RFP PROCESS, BUT POSTPONED THE COMPLETION OF THAT EFFORT UNTIL EARLY LAST YEAR. THE CURRENT PILOT PROJECT WILL BE EXTENDED IN SIX MONTH INCREMENTS UNTIL THE REINITIATION OF THE DENTAL RFP.

REDWOOD HEALTH FOUNDATION

THE REDWOOD HEALTH FOUNDATION (RHF) CONTRACT IS A VENTURE OF THE FOUNDATION FOR MEDICAL CARE OF SONOMA COUNTY. THE CONTRACTOR IS A KNOX-KEENE HEALTH PLAN ACT LICENSEE. THE DEMONSTRATION PROJECT IS FOR THE DELIVERY AND ADMINISTRATION OF THE FULL RANGE OF MEDI-CAL BENEFITS IN A THREE COUNTY AREA. IT IS SPONSORED BY:

REDWOOD HEALTH HOSPITAL CONFERENCE
HOSPITAL COUNCIL OF NORTHERN CALIFORNIA
REDWOOD EMPIRE PHARMACEUTICAL ASSOCIATION
SONOMA COUNTY MEDICAL ASSOCIATION
MENDOCINO AND LAKE COUNTY MEDICAL SOCIETY
REDWOOD EMPIRE NURSING HOME ASSOCIATION
REDWOOD EMPIRE PODIATRY ASSOCIATION

ALL MEDI-CAL BENEFICIARIES IN PUBLIC ASSISTANCE CATEGORIES ARE COVERED BY THE CONTRACT AND RHF IS COMPENSATED FOR THEIR CARE ON A CAPITATION BASIS (FY 1980-81 = $38 million). CURRENTLY, THE PROJECT COVERS ABOUT 44,000 PUBLIC ASSISTANCE BENEFICIARIES IN THE SERVICE AREA OF SONOMA, LAKE, AND MENDOCINO COUNTIES. THE GEOGRAPHIC AREA COVERS AN AREA OF 6,434 SQUARE MILES WITH A TOTAL POPULATION OF 318,200.

THERE ARE CURRENTLY ABOUT 1500 PROVIDERS OF ALL TYPES IN THE THREE COUNTY AREA. OF APPROXIMATELY 500 POTENTIAL RISK PROVIDERS IN THIS GROUP, 285 PHYSICIANS, 70 PHARMACIES, AND 6 PODIATRISTS HAVE VOLUNTARILY EXECUTED RISK AGREEMENTS WITH RHF. RHF BENEFICIARIES MAY ALSO RECEIVE SERVICES FROM ANY MEDI-CAL PROVIDER OUTSIDE THE SERVICE AREA.

GENERAL OBJECTIVES OF THE STATE

A CONSISTENT THEME SINCE 1978 HAS BEEN THE NEED FOR STRUCTURAL REFORM IN THE WAY WHICH MEDI-CAL SERVICE DOLLARS ARE CONVERTED INTO SERVICES FOR OUR CLIENTS. A CENTERPIECE OF THAT STRUCTURAL REFORM HAS BEEN AN EMPHASIS ON THE USE OF ORGANIZED HEALTH SYSTEMS CONTRACTS TO REPLACE THE USUAL FEE-FOR-INDIVIDUAL SERVICE APPROACH DOMINANT IN THE MEDI-CAL PROGRAM. THIS EMPHASIS WAS BASED AS MUCH ON A CONVICTION THAT ORGANIZED HEALTH SYSTEM CONTRACTING WAS PREFERABLE TO FEE-FOR-SERVICE FORM OF PAYMENT, AS IT WAS ON CALIFORNIA'S TRADITION OF UTILIZING SUCH ORGANIZED SYSTEMS AS AN INTEGRAL PART OF MAINSTREAM MEDICAL CARE. THESE BELIEFS WERE REINFORCED BY THE IMPROVING QUALITY OF THE EXISTING PREPAID HEALTH PLAN PROGRAM WITHIN MEDI-CAL.

IN ADDITION TO MANAGING IT'S CONTRACTS WITH PREPAID HEALTH PLANS, CALIFORNIA DENTAL SERVICE AND THE REDWOOD HEALTH FOUNDATION, THE DEPARTMENT OF HEALTH SERVICES IS ACTIVELY DEVELOPING OTHER LESS TRADITIONAL TYPES OF ORGANIZED HEALTH SYSTEM CONTRACTS. THESE LESS TRADITIONAL TYPES OF CONTRACTS INCLUDE:

- o PRIMARY CARE NETWORKS OF INDIVIDUAL PRACTICING M.D.'s
- o PRIMARY AND COMMUNITY CLINICS
- o COUNTY ADMINISTERED HEALTH SYSTEMS
- o OTHER AGGREGATIONS OF PROVIDERS THAT MAY FORM A LEGAL CONTRACTING ENTITY

THE INCREASING LIKELIHOOD THAT FEDERAL LIMITATIONS ON FFP FOR MEDICAID CONTRACTS WILL BE REDUCED EITHER BY STATUTE OR REGULATION CHANGE, OR MORE IMMEDIATELY VIA WAIVER AUTHORITY, ENCOURAGES THE DEPARTMENT TO PURSUE AN AGGRESSIVE ORGANIZED HEALTH SYSTEMS DEVELOPMENT EFFORT WITHIN THE MEDI-CAL PROGRAM.

COUNTY/OHS PILOT DEVELOPMENT WORKLOAD

THE STATE IS CURRENTLY WORKING WITH (A) OR WILL SOON WORK WITH (B) THE FOLLOWING COUNTIES IN THE DEVELOPMENT OF COUNTY ORGANIZED HEALTH SYSTEMS.

ALAMEDA	(A)	SANTA BARBARA	(A)
FRESNO	(A)	SANTA CLARA	(A)
LOS ANGELES	(A)	SONOMA	(B)
MARIN	(B)	STANISLAUS	(B)

MENDOCINO	(B)	SUTTER	(B)
MERCED	(B)	TULARE	(A)
MONTEREY	(A)	VENTURA	(B)
RIVERSIDE	(A)	YOLO	(B)
SAN FRANCISCO	(A)	YUBA	(B)
SAN JOAQUIN	(B)		
SAN MATEO	(A)		

PHP/HMO CONTRACT PROPOSAL DEVELOPMENT WORKLOAD

THE STATE IS CURRENTLY NEGOTIATING WITH THE FOLLOWING HEALTH CARE PROVIDERS AND/OR QUALIFIED HEALTH MAINTENANCE ORGANIZATIONS (HMOS) IN THE DEVELOPMENT OF POTENTIAL CONTRACTING RELATIONSHIPS:

INSTITUTE FOR PREVENTIVE MEDICINE (VALLEJO, FAIRFIELD, BENICIA),
SERRA MEDICAL GROUP (SAN FERNANDO VALLEY),
SAN YSIDRO COMMUNITY HEALTH CENTER (SAN DIEGO - SAN YSIDRO),
PACIFICARE (LOS ANGELES AND SAN DIEGO COUNTIES),
FOUNDATION HEALTH PLAN (SACRAMENTO, YOLO, PLACER, EL DORADO COUNTIES),
RIVERSIDE KEY PLAN (RIVERSIDE COUNTY),
HEALTH GROUP INTERNATIONAL (VENTURA COUNTY),
HMO OF THE REDWOODS (SONOMA, LAKE AND MENDOCINO COUNTIES),
HEALTHNET (LOS ANGELES COUNTY),
TAKECARE (ALAMEDA COUNTY)

OTHER ORGANIZED HEALTH SYSTEMS PROPOSAL ACTIVITY

THE FOLLOWING ENTITIES HAVE EXPRESSED INTEREST IN DEVELOPING ORGANIZED HEALTH SYSTEMS TO SERVE MEDI-CAL BENEFICIARIES. EACH IS IN A DIFFERENT STATUS OF FEASIBILITY, PLANNING AND DEVELOPMENT, OR PILOT NEGOTIATION ACTIVITY.

MOUNT ZION HOSPITAL (SAN FRANCISCO) - HOSPITAL BASED OHS,

CHILDREN'S HOSPITAL OF SAN FRANCISCO - HOSPITAL BASED OHS,

SAN DIEGO NATIONAL MEDICAL ASSOCIATION - CAPITATED PRIMARY CARE NETWORK,

SINKER-MILLER MEDICAL GROUP (EAST OAKLAND) - CAPITATED PRIMARY CARE NETWORK,

BRANCH-JOHN HALE MEDICAL SOCIETY (SAN FRANCISCO) - CAPITATED PRIMARY CARE SERVICES

RICHMOND COMMUNITY HEALTH CENTER - CAPITATED PRIMARY CARE SERVICES

SPENCER MEDICAL GROUP (SACRAMENTO) - CAPITATED PRIMARY CARE SERVICES

SOUTHWEST LOS ANGELES MEDICAL GROUP - CAPITATED PRIMARY CARE SERVICES

DEMONSTRATION AND OTHER PROJECTS

THE FOLLOWING ARE PROJECTS THAT THE OFFICE OF ORGANIZED HEALTH SYSTEMS SHARES (COORDINATION, DIRECTION, EVALUATION, SPONSORSHIP) WITH OTHER STATE AND FEDERAL AGENCIES/ENTITIES.

HOSPICE DEMONSTRATION PROJECT - THIS PROJECT IS SPONSORED BY THE STATE AND FEDERAL GOVERNMENTS AND FIVE HOSPICE PROGRAMS WITHIN THE STATE. ALTHOUGH THE MEDICARE AND MEDI-CAL PROGRAMS REIMBURSE FOR SOME OF THE MEDICAL SERVICES RENDERED TO TERMINALLY ILL PATIENTS, MANY HOSPICE

SERVICES ARE NOT REIMBURSABLE UNDER CURRENT LAWS AND REGULATIONS. THE EVALUATION OF THE PROJECT WILL ANALYZE THE ADVANTAGES AND DISADVANTAGES OF INCLUDING HOSPICE AS A MEDICARE/MEDICAID BENEFIT.

MULTIPURPOSE SENIOR SERVICES PROJECT - THE PROJECT PROVIDES A COMPREHENSIVE ARRAY OF MEDICAL AND SOCIAL SERVICES TO FRAIL AND ELDERLY MEDI-CAL RECIPIENTS AT EIGHT SITES IN CALIFORNIA. THE PROJECT SEEKS TO FIND WHAT COMBINATIONS OF HEALTH AND SOCIAL SERVICES PREVENT OR REDUCE THE NEED OF INSTITUTIONAL SERVICES, AND AT WHAT COST OR COST SAVINGS.

SUMMARY

CALIFORNIA'S EXPERIENCE WITH PREPAYMENT FOR MEDICAID SERVICES HAS BEEN PROFITABLE AND INSTRUCTIVE. OUR TEN YEAR HISTORY HAS PROVEN TO US THAT PREPAYMENT AT-RISK CONTRACTS WITH HMOS AND OTHER ORGANIZATIONS CAN PROVIDE AN ECONOMICAL AVENUE BY WHICH TO PROVIDE QUALITY HEALTH CARE TO THOSE IN NEED. CONTRACTUAL ARRANGEMENTS MINIMIZE GOVERNMENTAL INTERVENTION IN THE PRACTICE OF MEDICINE BUT ALSO ALLOW THE STATE TO EXECUTE ITS RESPONSIBILITY TO ENSURE THAT ADEQUATE QUALITY CARE IS PROVIDED AND AT A REASONABLE COST. IT HAS BEEN OUR EXPERIENCE THAT PHPS CONSISTENTLY SAVE THE STATE 10-20% AS COMPARED TO FEE-FOR-SERVICE (17% FOR FY 81/82). IT IS OUR BELIEF THAT NON-HMO HEALTH SYSTEMS CAN ALSO GENERATE SAVINGS, PROBABLY AT A LOWER LEVEL. ONLY TIME WILL TELL, SINCE OUR EXPERIMENTATION WITH NON-HMOS IS RECENT AND INCONCLUSIVE. IT IS CALIFORNIA'S DESIRE TO EXPAND THE USE OF NON-TRADITIONAL SERVICE DELIVERY AND PAYMENT SYSTEMS TO AS LARGE A DEGREE AS POSSIBLE. THE POTENTIAL SAVINGS IN A MEDICAID PROGRAM AS LARGE AS CALIFORNIA'S ($4+ BILLION ANNUM) IS PHENOMENAL

(1% = $40,000,000). IF CALIFORNIA CAN LOBBY A BIT HERE, WE'D LIKE TO REMIND THE COMMITTEE THAT MANY STATES ARE ON TENTERHOOKS IN TERMS OF PUBLICLY FINANCED PROGRAMS, WITH NO APPARENT ALLEVATION OF FISCAL CONSTRAINTS IN THE FUTURE. THE FEDERAL GOVERNMENT CAN HELP BY ALLOWING STATES TO BE INNOVATIVE IN TAILORING THEIR HEALTH CARE PROGRAMS IN TERMS OF BENEFITS, FINANCING AND ORGANIZATIONAL TYPES.

STATEMENT

BY

SAMUEL H. HAVENS, PRESIDENT

PRUCARE

and

VICE PRESIDENT, GROUP INSURANCE

PRUDENTIAL INSURANCE COMPANY OF AMERICA

PREPARED FOR THE

SENATE FINANCE COMMITTEE

HEALTH SUBCOMMITTEE

FOR

HEARINGS HELD ON

July 30, 1981

August 12, 1981

This statement is submitted on behalf of The Prudential Insurance Company of America by Samuel H. Havens, Vice President, Group Insurance and President of PruCare, Prudential's HMO subsidiary.

Prudential supports S. 1509, the Competitive Health and Medical Plan Act of 1981 (CHAMP), and we appreciate the opportunity to offer our observations and suggestions for this legislation.

At the outset I would like to summarize Prudential's involvement with HMOs so that the perspective from which we have developed our comments can be better understood.

Prudential's first direct involvement in HMO development was with the Harvard Community Health Plan starting in the late 1960s. Prudential representatives served as individual consultants to the plan in its early stages of planning and worked with the plan after it was launched.

Prudential's HMO management experience dates from 1973 when Prudential entered into a management contract with the Rhode Island Group Health Association (RIGHA), and agreed to lend it, at an appropriate interest rate, up to $1.5 million. At that time RIGHA was experiencing severe financial difficulty, and its ability to continue operations was in question. Prudential employees managed the plan through May 1980. By that time, the plan had become sound financially and was able to operate without assistance from Prudential employees. The Prudential loan is currently being repaid on schedule, and we are confident that the plan will continue to be successful.

Prudential has had experience with two additional HMOs which had been started prior to our involvement. The first was the Central Essex Health Plan, a prepaid group practice plan located in Orange, New Jersey. After this plan had operated unsuccessfully for a period of time and was rapidly drawing down its federal loan commitment, Prudential was asked by the Department of DHEW to consider taking over its management. Although we doubted our ability to make the plan viable, we agreed to assume management responsibility only because it was near our Corporate headquarters. No Prudential funds were invested in this HMO. After about one year of effort, which expanded enrollment and reduced expenses, it became clear that the plan would never be viable. The plan was closed down, with DHEW approval, when it still had $800,000 of ourstanding federal loans available. As far as we can determine, no plan member went without continuity of health benefits. There was no adverse employer or consumer reaction.

We were also invited by DHEW in 1975 to assume management responsibility for the Southshore Health Plan, an Individual Practice Association model HMO in Atlantic City. This plan had received federal planning and development grants, but was then denied qualification and operating loans. As a result, it had not commenced operations. We accepted the management responsibility without investing funds in the plan other than entering into a deferred arrangement for reimbursement of some of our expenses. The restructured plan was then granted qualification by DHEW. The plan has now reached an enrollment of 12,000 and is likely to continue to be viable. Prudential is still managing the plan.

The first Prudential-developed HMO started in Houston, Texas, in 1975. This plan uses the medical facilities of the MacGregor Medical Associates, a group practice which has been in operation for a number of years. This was the country's first federally qualified HMO which involved no federal grants or loans. The plan is financed entirely through Prudential capital and loans. The plan has more than met our expectations. The operations for 1979 produced net positive earnings one year prior to our original projections. Current enrollment is over 60,000, and we are optimistic that the plan will continue to grow rapidly.

In June 1979, we started an HMO in Dallas jointly with the Kaiser Permanente Medical Care Program. The Kaiser/Prudential Health Plan, which is jointly financed by the two organizations, is growing according to original plans and has financial results in accordnace with our expectations. Enrollment currently exceeds 20,000 persons.

Since 1980 PruCare has started new HMOs in Austin, Texas; Nashville, Tennessee; Atlanta, Georgia; and Oklahoma City, Oklahoma. Recently, in June 1981, PruCare acquired NorthCare, a Chicago, Illinois, HMO with 30,000 members. Over 100,000 persons now belong to PruCare HMOs in these various locations.

Twenty-four percent of eligible Prudential employees have also elected to receive their health care from one of the more than 45 HMOs made available

to company employees nationally. Our current role as owner, developer, manager, investor and customer demonstrates our commitment to HMOs.

Prudential has chosen to become active in this field for several reasons:

1. In addition to being providers of health care, HMOs provide economic security against the cost of illness. The provision of economic security to our customers is Prudential's fundamental purpose as an institution.
2. HMOs are a socially responsive and cost-effective method of providing health care. We believe they are in the best interest of the American public, the economy, and the health care system as a whole.
3. We believe that HMOs, when properly conceived and managed, can provide high quality and accessible health care in a competitive manner, while at the same time providing an adequate return on our investment.

Well managed HMOs have demonstrated their ability to contain costs and provide high quality health service to members. HMOs hold great promise for meeting the needs and solving some of the problems of our nation's health care system. It is most appropriate, therefore, that the Congress should consider arrangements which will make the benefits of HMO membership more widely available to older Americans.

HMO membership can be a valuable benefit to older Americans. Members receive coordinated care through an organized health care delivery system. The elderly would enjoy the benefits of physician guidance through the often confusing array of specialists and other services available for their care.

Access by the elderly to HMO membership has been frustrated, however, by the disadvantages of current Medicare reimbursement arrangements. For example, under currently available cost or risk-based arrangements final payment by Medicare to an HMO is made retrospectively and could remain undetermined and unpaid two or three years after services are provided. HMOs are also required to offer a Medicare benefit package that covers only Medicare-eligible services. This excludes preventive and health maintenance services and is alien to the concept of HMOs.

We believe that the adoption of an equitable system of prospective reimbursement can greatly expand the availability of comprehensive prepaid health care to Medicare recipients. For this reason we commend Senator Heinz and the cosponsors of S. 1509 for their recognition of the potential of HMOs and the realities faced by these organizations. If enacted, S. 1509 would be a significant step by the federal government to recognize competitive, cost effective health care delivery systems.

We endorse the basic framework of S. 1509, and we believe that with a few modifications the measure will create a workable mechanism to increase the availability of HMO membership to Medicare beneficiaries.

We believe S. 1509 would benefit greatly from the following modifications:

- Enrollment in both Parts A and B of Medicare should be a prerequisite of HMO enrollment under the CHAMP Act. This will help simplify administration by the HMO and hold down the costs associated with multiple categories of membership.

- The feature of the current HMO reimbursement law allowing HMOs to elect to have Medicare process Part A claims should be retained by the CHAMP Act. This feature is particularly suited to HMOs without a significant Medicare enrollment because it allows for the gradual assumption of this function at a later date.

- The disenrollment provision of the CHAMP Act should be revised to provide for disenrollment only during the annual open enrollment period, upon relocation from the service area or upon termination of Medicare eligibility. This arrangement will provide some minimal protection to the HMO against adverse selection. Medicare members would thus be treated in the same fashion as non-Medicare HMO members.

- The CHAMP Act includes quality of care standards which will apply to participating Competitive Medical Plans. Federally qualified HMOs are already required to meet comprehensive quality of care standards under the federal HMO Act. Coordination between the agencies administering these two very similar sets of requirements should be mandated by law to avoid adding a layer of duplicative regulatory burdens.

- Historically, HMO boards of directors have shown themselves to be responsive to the needs of HMO members. Board decisions on HMO policy and coverages are made with serious consideration of member interest. Federally qualified HMOs are required to have one-third of their board membership for HMOs made up of consumer members. We feel that these boards are capable of deciding how and when any savings experienced under the CHAMP Act should be applied to additional services, capital investment, premium rebates or retention of profits. The bill should not mandate how the difference between the Adjusted Community Rate and the Adjusted Average Per Capita Cost must be spent. Appointing a panel of Medicare members to make such decisions could also cause dissension among non-Medicare HMO members.

- One key to the success of the CHAMP Act would be the ability of HMOs and the Secretary of HHS to agree on the Adjusted Community Rate for each plan. This process raises the prospect that HCFA will engage in determining allowable HMO expenses in much the same fashion as is currently the case with hospitals. The attractiveness of the CHAMP Act would be largely reduced if HCFA is to set HMO salaries or the acceptable costs of marketing to individual Medicare enrollees, depreciation schedules and chargeable interest rates.

- The CHAMP Act makes provision for how funds should be used if the Adjusted Community Rate is less than the AAPCC. The Act should also make provision for the recoupment and amortization of losses by an HMO should the 95% of AAPCC prove inadequate.

Health maintenance organizations can provide a cost effective, comprehensive health care alternative for Medicare beneficiaries. With the modifications we have suggested, this alternative can be made more available to elderly Americans with concurrent cost savings to the federal government.

STATEMENT OF THE

AMERICAN ASSOCIATION OF FOUNDATIONS FOR MEDICAL CARE

FOR THE

SUBCOMMITTEE ON HEALTH,

COMMITTEE ON FINANCE

U.S. SENATE

SUBMITTED FOR THE PRINTED RECORD OF THE HEARINGS OF

JULY 30, 1981

We appreciate the opportunity afforded by the Subcommittee to present the position of the American Association of Foundations for Medical Care (AAFMC) on Medicare and Medicaid reimbursement for Health Maintenance Organizations and similar health plans.

The AAFMC is the national association representing Individual Practice Association-type Health Maintenance Organizations and Foundations for Medical Care. The AAFMC has 86 member organizations which, in turn, have more than 20,945 physicians participating in their programs. About 1,309,000 Americans are now enrolled with our member organizations.

While the physician members of our organizations are among those who care for Medicare and Medicaid patients, in most instances they are doing so in the traditional basis of providing health care rather than as members of our plans. Witnesses have testified before Congress for years now that the present system of reimbursing HMOs under Medicare is not attractive to either beneficiaries or the HMOs -- this explains, in major part, the reason why our plans are not involved. The formula's basic flaw is that it is retroactive in many respects and, for that reason, is simply not consistent with the way HMOs work.

As our members have become more experienced in managing their programs, we see a growing interest in extending their membership to Medicare patients. IPA-type HMOs have particular advantages for the aged which should facilitate their joining this form of health care delivery. The IPA-type HMO or a foundation for medical care, since it typically includes a majority of the physicians in an area, can enroll Medicare patients without requiring them to change physicians. In addition, since our plan physicians are located throughout the geographical area, aged people have better access to physician

care at lower travel costs than would be the case if they were to receive their care at one or two central clinics.

The problems with the present law would be substantially solved under the provisions of S. 1509. We are especially pleased also that organizations other than those which have chosen to seek federal qualification as HMOs will be able to participate in the program. Many of our members have chosen not to seek federal qualification -- some are qualified under state law, others have been established for two decades or more and are not certified as HMOs by any government body.

We are also very supportive of the provisions which require that all reimbursement in excess of the adjusted community rate be furnished to the beneficiaries in the form of additional benefits or even cash rebates. The administrative effort in the cash rabate provisions may prove difficult for some of our members. However, we are generally supportive of the concept and will be glad to work with you, your staff and others to make the provision work as simply as possible -- from the standpoint of the beneficiary as well as the plan.

In our view, the provision which would permit a group of Medicare patients to select the added benefits is not necessary. We believe that the individual plan should make that decision and then the individual medicare beneficiary should be permitted to select the plan with the benefits most suitable to his circumstances.

Finally, while we strongly support the purposes of the bill, we would hope that in marking up the legislation, the committee would question closely the necessity of each provision which gives the Secretary regulatory discretion. We understand the need for protection for this public program

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and its beneficiaries, but we are also aware that the more requirements and the more regulations which are imposed, the less likely the system will work in the way we all intend.

We appreciate very much the opportunity to present our position to the committee, and we urge that our recommendations be given careful consideration.